ADMINISTRATION OF MEDICARE COST-SAVING EXPERIMENTS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

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94th Congress/2nd Session/1976

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WITNESSES

ADMINISTRATION OF MEDICARE COST-SAVING EXPERIMENTS

FRIDAY, MAY 14, 1976

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met at 10:20 a.m., pursuant to notice, in room H–208, the Capitol, Hon. Charles A. Vanik (chairman of the subcommittee) presiding.

Mr. VANIK. The committee will be in order.

In the 1972 Social Security Amendments, Public Law 92–603, section 222, the Congress directed the Secretary of HEW to conduct experiments and demonstration projects designed to determine the cost effectiveness of prospective payment.

Generally speaking, prospective reimbursement is "forward budgeting" whereby the amount or rate a facility may be reimbursed for health services is established prior to the period over which the services will be provided. Presently, of course, hospitals submit bills to intermediaries and thus to medicare for services subsequent to the rendering of that service. Prospective reimbursement would substitute "future" budgeting for the present retroactive reimbursement.

Proponents of prospective rate payment believe that such a system should motivate health care providers to become more efficient in their utilization of resources while, at the same time, maintaining their quality services. Others have strongly contested these claims.

Since the passage of the 1972 amendments, several experimental prospective reimbursement systems have become operational. It is the purpose of the subcommittee to determine some of the cost advantages and disadvanages of these systems. As we move into a period of ever-increasing Federal and State participation in health care financing, it is crucial that we begin to identify and understand potential gains and losses associated with alternative cost containment strategies.

As a member of the Ways and Means Health Subcommittee, I want to say that it is very important that we begin to discuss, now, the lessons available from prospective reimbursement experiments. America is currently spending $118 billion on health services—a 300-percent increase in the past decade. Last year, hospital cost inflation was 13 percent, and this year it is estimated at 15 percent.

To help control this incredible inflation, members of the Health Subcommittee have suggested that the subcommittee's proposed 1976 medicare bill include a phase-in of prospective reimbursement pro-

cedures over the next 4 years. It is vital that HEW begin to give priority attention to its work in prospective reimbursement and to the areas where more experimentation is needed.

To help us understand the possibilities and the limits of prospective reimbursement, we have with us today a panel of three experts who have or currently are working on SSA-supported prospective reimbursement experiments. In addition to hearing about their findings to date—and we recognize that conclusive findings may not yet be available—we would like to hear from them about the level of support and encouragement Social Security has provided for this program.

We will also hear from Social Security officials in charge of these experiments. We hope that they will tell us what they feel they have learned to date, where they feel there are gaps in our knowledge of the feasibility of prospective reimbursement and what they plan for future research and demonstration.

Will the panel please come forward first.

These are Mr. John Griffith, professor, University of Michigan School of Public Health; Dr. Harold Cohen, director of Maryland State Health Services Cost Review Commission; and Mr. F. Bernard, Forand, executive director, Commission on Hospitals and Health Care, State of Connecticut.

Are you related to the former Member of Congress?

Mr. FORAND. No, sir, I am not.

Mr. VANIK. We will hear, first, from the panel. Why don't we start with you, Mr. Griffith, and then we will proceed to the rest of the panel.

A PANEL CONSISTING OF JOHN GRIFFITH, PROFESSOR, UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH; DR. HAROLD COHEN, DIRECTOR, MARYLAND STATE HEALTH SERVICES COST REVIEW COMMISSION; AND F. BERNARD FORAND, EXECUTIVE DIRECTOR OF THE COMMISSION ON HOSPITALS AND HEALTH CARE, STATE OF CONNECTICUT

Mr. GRIFFITH. Thank you.

I am professor of hospital administration and director of the program bureau of hospital administration at the University of Michigan School of Public Health. Many people in Michigan have worked hard to control hospital costs, and I believe we are developing an effective effort to get the job done.

Actions taken by Blue Cross and Blue Shield of Michigan will reduce hospital payments by $60 million for 1976. There may be additional savings for medicare and medicaid. That number is strictly for Blue Cross' own payments.

We will continue to control hospital costs in the future, but our efforts will require several years to reach complete fruition. We will need more assistance from medicare and medicaid in future years since these agencies are not involved at all in current actions.

The Michigan experience and the reports worked on elsewhere in section 222 of the amendments of 1972 lead me to make the following suggestions, which I draw as lessons from the 222 research

No. 1, retrospective cost base reimbursement is no longer an effective or desirable way to pay hospitals in any situation where it dominates

or even has a large fraction of total hospital income. The Congress therefore should stimulate a shift to prospective reimbursement for all medicare and medicaid funding.

No. 2, the best methods of prospective reimbursement have not yet been developed and there are probably a wide variety of programs suitable to different States or even parts of States. The Congress, therefore, should not mandate a single form of prospective reimbursement. It should continue experimentation and encourage flexibility and variety in the application of prospective reimbursement systems.

It should also encourage collaboration between governmental and voluntary agencies such as Blue Cross. The opportunity to increase impact by integrating several third-party sources together should not be overlooked. In this regard wording like that found in section 102 of the bill introduced by Congressman Mills, Health Care Management Act of 1974, would permit Michigan and other States to continue to analyze and solve their own problems with their own resources.

I regret that I cannot find similar wording in S. 3205 for the current Congress submitted by Senator Talmadge.

No 3, the Congress should establish or have the Secretary of HEW establish guidelines as to acceptable increases in costs of hospital care. These could apply to both medicare and medicaid, but they would also be useful as advice to private funding agencies. These guides should be established for States or regions in terms either of per-person or total annual costs. In no case should they be established in terms of per-diem costs. Per-diem cost guidelines provide incentive for increased unnecessary utilization of hospitals and fail to attack the most serious and rewarding area of inefficiency, that of inappropriate use.

No. 4, the Congress should continue to fund section 222 activities and should continue to stimulate research and evaluation of the various approaches to prospective reimbursements which have and will develop among the States. To lose the data base that we have gained so far would be to waste most of the benefits of the investments we have made in section 222 and would, in my opinion, be a serious loss.

We will use in Michigan not only the local data funded through this section, but also the studies in other States.

No. 5, the Congress should encourage greater cooperation by the Bureau of Health Insurance with well-conceived State and voluntary programs. It is obviously difficult for the BHI to comply with this. It seems to me their compliance is necessary and even vital to a sound, well-conceived national program.

Mr. Chairman, the gentleman to my left says that may be correct, but that the BHI is forbidden by law to provide that kind of support.

As an addendum to these remarks I am submitting a review of major contributions from section 222 research and some documentation of the cost control problem in Michigan.

I have given Congressman Vander Veen's staff an article which shows that his district, Grand Rapids, is probably the most efficient hospital care delivery area in the State of Michigan, and that its costs per person in Grand Rapids are about half what they are in Detroit.

I have included section 102 H.R. 13461, the 93d Congress. That is the Mills bill section I referred to.

Thank you, Mr. Chairman.

[The supplemental document referred to follows:]

EXCERPT FROM H.R. 13461, 93D CONGRESS

SEC. 102. In addition to the method or methods for establishing prospective rates or amounts made available under section 101, the Secretary may make available to hospitals in a State or any other region or geographic area designated by the Secretary another method for establishing prospective rates or amounts where the Secretary finds that the State or regional plan for prospective payment, as developed by either the State, hospitals or a hospital organization, or a third party payor, is consistent with the policies expressed in this Act.

Mr. VANIK. Thank you.

Dr. Cohen, we would be happy to hear from you.

STATEMENT OF DR. HAROLD COHEN

Dr. COHEN. Mr. Chairman, members of the subcommittee, my name is Dr. Harold A. Cohen. I am executive director of Maryland's Health Services Cost Review Commission. I have been advised that you have many questions to address the panel and that any opening remarks should be quite short indeed. I will, of course, follow that pattern.

The Health Services Cost Review Commission was established as a unique agency in July 1971. Beginning July 1974, it assumed its hospital rate regulatory authority. The commission's specific responsibilities include: (1) assuring the public that a hospital's aggregate costs are reasonably related to the services it performs, that is, that the hospital is efficient and effective; (2) that a hospital's aggregate revenues are reasonably related to those aggregate costs—specifically that efficient and effective institutions remain solvent; and (3) that the hospital's rates are set equitably among all purchasers and classes of purchasers of the hospital's services, that is, that no undue discrimination exists in the rate structure.

The most significant aspect of the law is that of prospective rate approval. The commission's primary job is to establish an atmosphere in which hospitals will have the incentives to control their own costs. This is done by approving reasonable budgets and by applying controlled inflationary rates to that budget.

Hospitals, thus, use their expertise to prove that their departmental budgets are reasonable and contain costs within the inflation monitoring system. Their expertise would not be used, as it has been, to prove that they did spend the money and to juggle accounting figures so as to maximize retroactive reimbursement of incurred costs by medicaid, medicare, and Blue Cross.

You are probably interested in whether the commission has achieved results. Since July 1, 1974, hospital rates in Maryland, over the 22-month period, have increased at a fairly consistent annual rate of 7 percent. Costs are increasing at an annual rate of 9–10 percent. This contrasts with, for example, the recent report of the Council on Wage and Price Control which states that hospital costs went up 20 percent during the past quarter and other data indicating that costs and charges went up 13–16 percent last year.

Finally, I am distributing, for your information, copies of a recent release by the Bureau of Labor Statistics. That release presents CPI data by city for medical care and its components over the past 7 years.

I call your attention to the relationship between the city average and the Baltimore figures for hospital charges, specifically, that last year the Bureau of Labor Statistics reports a Baltimore rate of increase of 3.8 percent compared to the all-city rate of increase of 13 percent.

As that table shows, in the early years before the commission was created, Baltimore's rate of increase in hospitals' daily service charges far outstripped what was happening in the country as a whole. In 1974, when the commission began regulating hospitals in the middle of the year, the Baltimore rate fell to below the national average and last year—and this is the next to the last line on the page—it shows that whereas Baltimore showed a 3.8 percent increase, other cities listed showed at least 11, that is double digit.

Mr. VANIK. Thank you very much.

[The table follows:]

CONSUMER PRICE INDEX

ANNUAL PERCENTAGE CHANGES FOR MEDICAL CARE SUBGROUPS, U.S. CITY AVERAGE AND SELECTED LARGE METROPOLITAN AREAS

	U.S. city average	Atlanta	Baltimore	Chicago	Detroit	Los Angeles	New York	Philadelphia	St. Louis	San Francisco
December 1968–December 1969:										
Medical care	6.0	8.9	8.1	5.7	6.6	6.6	8.7	7.4	5.4	5.3
Medical care services	7.1	10.5	9.4	6.8	7.1	7.1	10.7	8.4	6.0	5.7
Physicians' fees	7.3	8.1	6.7	3.5	8.0	9.8	10.1	8.0	6.0	4.7
Dentists' fees	7.5	11.9	4.7	14.7	6.1	3.4	9.8	7.1	8.8	6.7
Hospital daily service charges	12.0	19.5	23.9	11.9	13.3	8.4	21.0	18.3	7.7	14.3
Drugs and prescriptions	1.1	.3	1.5	.5	2.1	3.6	—.2	2.8	2.5	2.6
December 1969–December 1970:										
Medical care	7.4	8.0	11.5	8.5	10.3	5.6	10.1	10.6	6.7	5.2
Medical care services	8.3	9.0	13.2	9.6	10.9	6.1	10.9	12.6	7.8	5.5
Physicians' fees	8.1	9.3	8.1	6.5	7.7	7.0	14.0	6.7	3.6	8.1
Dentists' fees	5.6	3.9	10.2	8.3	13.8	6.2	2.8	9.2	9.9	3.0
Hospital daily service charges	13.5	8.0	26.4	16.7	22.8	8.8	16.7	24.9	14.9	5.2
Drugs and prescriptions	2.4	2.0	2.2	2.9	5.2	2.9	5.3	—.2	.9	3.6
December 1970–December 1971:										
Medical care	4.8	5.4	8.0	3.7	7.0	4.4	5.0	4.7	3.0	5.0
Medical care services	5.3	6.3	9.6	5.1	7.3	4.9	5.3	5.4	3.3	5.8
Physicians' fees	5.2	4.8	10.2	3.7	5.7	2.7	4.5	4.1	5.2	5.4
Dentists' fees	6.4	1.9	7.3	6.7	9.4	5.7	6.5	8.7	1.6	7.3
Hospital daily services charges	8.9	11.3	14.9	11.2	11.8	13.2	9.8	11.6	5.3	10.3
Drugs and prescriptions	1.3	0	—1.9	—3.5	3.8	1.3	3.3	.5	.7	.1

December 1971–December 1972:										
Medical care	3.3	3.0	4.4	3.5	4.1	3.1	3.8	3.7	2.3	4.2
Medical care services	3.8	3.2	5.0	4.2	4.4	3.3	4.6	4.3	2.5	4.9
Physicians' fees	2.4	.2	2.6	1.6	1.0	1.8	4.9	2.7	1.5	3.2
Dentists' fees	2.8	7.3	4.7	2.9	1.1	.6	2.9	.7	.5	4.2
Hospital daily service charges	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Drugs and prescriptions	0	1.6	.1	−.4	1.4	.6	−.3	−.3	.6	−.4
December 1972–December 1973:										
Medical care	5.2	6.9	6.7	5.2	6.8	6.1	4.1	6.3	5.4	4.2
Medical care services	5.8	7.8	7.7	5.8	7.6	7.2	4.9	7.0	6.2	4.7
Physicians' fees	4.0	4.9	4.2	4.7	6.0	4.4	4.0	7.5	3.3	2.2
Dentists' fees	3.7	4.2	6.8	1.9	2.0	9.1	.9	5.1	2.4	3.6
Hospital daily service charges	4.3	6.7	5.3	4.6	3.8	4.7	4.8	2.2	4.9	4.5
Drugs and prescriptions	.7	1.2	.5	1.8	−1.3	−.5	−.2	1.0	.7	.2
December 1973–December 1974:										
Medical care	12.4	12.6	10.9	12.9	12.0	12.3	14.0	11.1	11.2	11.6
Medical care services	13.3	13.8	11.5	13.9	11.8	13.0	14.5	11.9	12.0	12.5
Physicians' fees	13.3	13.6	9.8	11.6	11.7	13.6	12.0	11.1	11.8	14.3
Dentists' fees	11.4	9.6	15.4	14.0	17.8	9.3	12.2	11.8	12.2	9.9
Hospital daily service charges	14.2	16.7	11.5	14.9	8.0	13.4	18.6	12.7	13.6	12.5
Drugs and prescriptions	6.9	4.0	5.8	6.0	14.8	7.1	10.5	5.9	6.4	5.4
December 1974–December 1975:										
Medical care	9.9	11.2	6.4	11.2	14.3	12.1	10.3	12.3	7.6	14.3
Medical care services	10.3	11.4	5.7	11.8	15.1	13.1	11.0	12.8	8.2	15.3
Physicians' fees	11.8	10.5	9.9	9.7	15.8	20.1	15.8	10.1	5.4	23.8
Dentists' fees	7.8	12.8	8.0	10.6	10.4	4.9	4.4	6.2	16.1	4.1
Hospital daily service charges	13.0	13.0	3.8	19.4	20.3	16.3	11.3	23.0	11.7	15.5
Drugs and prescriptions	7.4	9.8	12.3	6.7	5.7	4.4	9.4	8.6	3.6	6.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, Washington, D.C. 20212.

Mr. VANIK. We will proceed to Mr. Forand and then we will have a discussion with the panel. You may proceed, Mr. Forand.

STATEMENT OF F. BERNARD FORAND

Mr. FORAND. Mr. Chairman, members of the subcommittee, my name is F. Bernard Forand. I am the executive director of the Commission on Hospitals and Health Care for the State of Connecticut. The commission, established in 1973, has broad powers to review and approve budgets and rates of hospitals, nursing homes, and other health care institutions. It also has extensive powers to review and approve all health care facilities and new services in the State where the costs exceed $25,000.

I assumed the position of executive director of the commission in late March of this year. Previously, I was employed for over 3 years as chief negotiator for the State of Rhode Island in matters pertaining to the negotiations of hospital rates for the title XIX program. I am appearing today at the request of the subcommittee to describe briefly Rhode Island's experience thus far under a 3-year experiment in prospective budgeting which was funded by the Social Security Administration beginning in October 1974, pursuant to section 222 of Public Law 92–603.

My testimony will consist of a brief description of Rhode Island's prospective reimbursement system followed by some tentative conclusions I have made on the progress of the experiment to date. Upon conclusion of my testimony, I will be happy to answer any questions which the subcommittee may have regarding the Rhode Island experiment in prospective reimbursement.

First, let me emphasize that the Rhode Island experiment is the only experiment funded by the Social Security Administration which involves a voluntary approach to regulating hospital costs. All 16 of the State's voluntary hospitals, acting through the Hospital Association of Rhode Island, have participated as a full partner with Blue Cross of Rhode Island, and the State Budget Office in the design and implementation of the experiment. Let me also emphasize that all major third parties, including Blue Cross, medicare, and medicaid, are participating in the experiment. Together they account for about 85 percent of patient days rendered in the voluntary hosiptals. The only classes of patients not included in the experiment are the self-paying patients and patients covered by the commercial insurance companies.

The experiment was designed to demonstrate that a statewide program of prospective rate setting with incentive based on budget negotiations within a statewide limit on total allowable cost increases has substantial power to:

Contain costs;

Assure that growth in programs is based on statewide need;

Shift some proportion of health dollar investments from inpatient to other patient care modalities;

Insure that cost control efforts do not have a deleterious effect on patient care; and

Reward management efficiencies and improved productivity.

There are several major features of the Rhode Island prospective rating system:

The key feature of the experiment is the negotiation of a maximum, total outside limitation on all elements of hospital costs in the State for the year, including new programs and volume. This feature is called a Maxicap and is negotiated prospectively in the spring preceding the budget year which begins on October 1.

For 1974–75, the increase over actual 1973–74, expenses was negotiated at 13.85. In 1975–76, the increment negotiated was 11.5 percent. Maxicap negotiations for 1976–77 were completed last week, and the increment negotiated was 10.5 percent.

Following negotiation of the Maxicap, Blue Cross, and the State Budget Office acting in concert negotiate individual budgets with each of the voluntary hospitals in the State. The system has flexibility in that while an individual hospital's budget may exceed the Maxicap increment, the sum of all the hospital budgets must be within the Maxicap.

For example, if the Maxicap is 11.5 percent, it is conceivable that one hospital would get a 13-percent increase and another, a 7-percent increase; yet the sum of all the hospital budgets would have to be within the 11.5 percent Maxicap increment.

In fact, the sum of the budgets are negotiated at a level about one percentage point below the Maxicap so that a reserve is available to absorb major contingencies or variable expenses for volume which exceed negotiated budgeted levels. Because the Maxicap includes a fixed ceiling on the incremental costs of hospital care in the State, the system encourages competition among hospitals for as large a share of the Maxicap as they can individually justify to third parties. As an incentive to hospitals to become more efficient, hospitals which spend under budget are allowed to retain any savings; by the same token hospitals which exceed their budgets must absorb any losses. Thus, there is a clear incentive under the experiment for a hospital to remain within its budget.

The program also includes a mechanism under which all medically related programs above a certain dollar level must be reviewed by a project advisory committee of the State's voluntary Health Planning Council as a condition of inclusion in a hospital's budget. I might add that both Blue Cross and the State government are represented on the project advisory committee. This committee identifies and ranks programs having a demonstrable community need in the budget year. Programs not considered essential for implementation are given low priority rankings and are not funded by third parties. While the highest ranked programs are not guaranteed funding, most such programs are approved for incorporation into the appropriate hospital's budget and become includable in the Maxicap limitation.

To strengthen the cost containment effects of the prospective budgeting system, the State budget office, with strong support from Blue Cross, succeeded in negotiating with the hospitals an agreement to implement a concurrent utilization review system in every hospital in January 1975. This program was given high priority following a study in which we found the length of stay in hospitals in Rhode Island to be approximately 2 days higher than stays for patients with comparable diagnoses in the West. Because we could not find a legitimate basis for this significant variation in length of stay, we decided to implement a system of concurrent review.

The system was modeled after chapter VIII of the PSRO manual to facilitate a smooth transition to an eventual takeover by Rhode Island PSRO, Inc., when it became operational. Since the date of implementation, every hospital in the State has decreased its length of stay, in some cases by more than one full day. Continuing emphasis during budget negotiations is placed on admissions and patient days to minimize the possibilities of overutilization.

OBSERVATIONS ON THE EXPERIMENT

1. There is evidence that the Rhode Island system of prospective reimbursement—voluntary as it is—has been somewhat successful in retarding the hospital cost spiral. I do not believe it has contained the cost spiral in hospitals, but it is probably doing a better job statewide than most other States in the country.

2. There is clear evidence that hospitals in Rhode Island are paying significantly more attention to cost control than they have in the past. Since the experiment began, there have been several shifts in key positions within several hospitals in the State.

3. Hospitals are giving increased emphasis to reallocation of resources to add new programs and services. This is due to increased recognition that health resources aren't infinite, and that tradeoffs are sometimes necessary to achieve desired objectives.

4. Perhaps one of the most significant outcomes of the experiment is the demonstration that third parties, such as Blue Cross and the State, through joint cooperative efforts can achieve cost containment measures which either party individually might be unable to achieve. The combination of State power coupled with traditional Blue Cross reimbursement expertise and staff resources places the third parties in a powerful position to deal effectively with the not insignificant economic and political power of hospitals.

5. The one major disadvantage of the Rhode Island experiment is that it is incredibly time consuming. All parties spend literally 12 months of the year in negotiations and renegotiations of the many myriad issues relating to the experiment. The complexity of the issues accounts for much of the time spent in the process. However, another major factor is the inability of the hospital negotiation team to make firm commitments for the hospitals, thus necessitating a constant renegotiation of issues which the third parties had previously thought resolved.

I would like to make a few general comments.

1. In the absence of sophisticated types of prospective reimbursement mechanisms, States could effectively retard or perhaps even contain the hospital cost spiral through the use of a Maxicap or ceiling on hospital cost increases. Such a mechanism might be applied across the board to all hospitals initially as a way to hold down hospital costs until such time as a State could develop a more sophisticated approach which takes into account differences in productivity and efficiency among hospitals.

To implement such a system States would have to secure the cooperation of Blue Cross and the major commercial insurance carriers as well as obtain exemptions from the Social Security Administration regarding the titles XVIII and XIX cost principles. To achieve

these objectives States would very likely have to demonstrate an ability and a willingness to administer an effective cost containment program, something which few States could do at this time.

2. Any system of prospective reimbursement must include all major third parties. To the extent it fails to do so, hospitals will shift the burden of cost containment measures instituted by third parties covered by prospective reimbursement to parties which are not covered.

3. Prospective reimbursement systems must include total operating expenses of the hospital, including capital, new medical programs and volume. To the extent that any elements of hospital costs are omitted from a prospective reimbursement system hospitals will be encouraged to increase spending in these noncovered areas.

4. Volume controls are essential based upon an appropriate fixed/variable formula to minimize the cost to the health care system of the explosive growth in ancillary services.

5. Effective productivity screens are required to measure base period costs among hospitals of like size and case-mix to force inefficient hospitals to reduce unit costs deemed incompatible with efficient management. These systems will require the development of uniform functional accounting systems in hospitals to assure comparability of data.

6. Formal linkages between certificate-of-need agencies, planning agencies and rate setting agencies are essential to insure an overall effective system of most containment in hospitals.

7. In designing prospective budgeting systems one must take into consideration both costs and utilization, the point that Dr. Griffith also made and one that can't be overemphasized. You have to deal with both the efficiency issue and the overutilization issue, and assure that the cost containment program does not contain built-in incentives to increase utilization.

8. Ideally any prospective reimbursement system should control both costs and revenues rather than only one of these elements.

This concludes my testimony. I thank the subcommittee for the opportunity to present my views and would be happy to comment further on any aspects of my presentation.

Mr. Vanik. Mr. Forand, I want to thank you for your testimony.

I just have two or three questions that I want to ask of the panel.

First of all, I would like to inquire whether under Maxicap programs the cap doesn't become a floor. In other words, if you set 10 percent this year, will any hospital come in under that figure?

Mr. Forand. That is a very good question. The first year the cap was set at 13.85 percent and the hospitals on the average asked for 18 percent, which meant that we had to eliminate on the average about 5 or 6 percent from each hospital's budget to get the aggregate percentage increase below the Maxicap increment. However, in the first year of the program, 2 of the 16 hospitals asked for less than the 13.85 percent; in each case though, the amount requested was slightly higher than 13 percent. Thus, for all practical purposes, it is valid to state that the hospitals considered the Maxicap to be a floor.

Mr. Vanik. One of the things that concerns me is the problems we have in local utility rates where, for example, the utility probably wants a 6-percent rate and will ask for 12. Then the vigorous efforts of the public officials will make a great saving and settle at 9, which is 3 percent more than utility, wanted in the first place.

Mr. FORAND. You must remember that in Rhode Island the experiment is voluntary, not mandatory. The key element of the experiment is the negotation of the Maxicap. For the year beginning October 1, and I didn't participate in the process this year, the parties negotiated a Maxicap of 10.5 percent. I think if total hospital costs nationwide increased "only" 10.5 percent next year including volume, new programs and capital expenditures, the country would probably save several billion dollars.

Mr. GRIFFITH. Mr. Chairman, may I comment on the question? The action in Michigan is a result of the major buyers of hospital care, particularly General Motors and United Auto Workers, saying they would pay no more than the 10-percent increase.

Mr. VANIK. You have a strong consumer group there that is functioning in your State.

Mr. GRIFFITH They appear to be very strong and getting stronger every day, yes, sir.

Mr. VANIK. How much do you think you have saved in the Connecticut plan? What has been the saving in Rhode Island?

Mr. FORAND. It is hard to guess at this point. I think perhaps we have retarded the spiral, but I don't think we have contained hospital costs. Most of my colleagues in the State rate-setting agencies share my view that they would like to see hospital costs increases limited to the level of increase of general inflation in the economy.

No State, however, has been able to achieve this objective. To answer your question, I would hesitate to give a firm number on how much we have saved. I think perhaps that we have held the inflationary spiral 1 to 2 or perhaps 3 percent below the nationwide increase in total hospital costs.

Mr. VANIK. I would like to ask Dr. Cohen about the Maryland plan. You faced a challenge in the courts, didn't you?

Dr. COHEN. Yes.

Mr. VANIK. Would you tell us about that? What happened?

Dr. COHEN. We were challenged by the hospital association primarily on our guidelines, which we said weren't regulations, and they also challenged us on the grounds that we had considered Blue Cross to be a class of purchaser.

More importantly, they said that if hospitals can demonstrate to the commission that they have presented a reasonable rate structure, then the commission had to approve it even if the commission found something to be more in the public interest.

The district court held for the hospitals on every item. We didn't appeal the finding that the guidelines were void as regulations because we had told the judge we didn't think they were regulations anyway and didn't use them that way.

With regard to the matter of Blue Cross being a purchaser, the court—and by the way, they also held that medicare and medicaid were not classes of purchasers—the court said that while Blue Cross was not a class of purchaser, the court could not say anything about medicare and medicaid, and if Blue Cross could demonstrate cost savings, they were entitled to a discount. Whether they of themselves were a class of purchaser or not, their individual patients together were certainly a class of purchaser.

The third point and the most important point, the court overruled the district court. They reversed and found that the commission had the full authority to select whatever rate structure and set of rates they found to be most reasonable given the testimony presented. So we were very pleased with the outcome.

Mr. VANIK. That is the result of the litigation. Now what did Social Security do when you were in litigation?

Dr. COHEN. Previous to litigation the experiment that we had or the contract we had with Social Security was that Social Security helped contribute financially toward the development of our ratesetting methodology about $200,000, which they gave us to help us develop the methodology. They were not paying our rates and they still are not paying our rates.

We had to continue with a more major contribution, a more major contract, and during the litigation I think the thing that SSA did was hold up any further negotiation with us until they saw what happened. That is if the court, indeed, said that medicare and medicaid were not classes of purchasers and could not be recognized, that their existence could not be recognized by the commission, then I think that they would have simply stayed away from us completely; thus, they wanted to see what happened.

That is what the district court had said. But when the appeals court reversed, they again became interested in the commission—or rather, they started to indicate that they were now ready to support the commission's activities.

Mr. VANIK. Thank you very much.

Mr. Pike?

Mr. PIKE. Thank you, Mr. Chairman.

Dr. Cohen, what criteria do you use in order to determine what a fair rate of return for a hospital is? Who says what a fair rate of return for a hospital is?

Dr. COHEN. Do you mean a proprietary hospital?

Mr. PIKE. Let's take a proprietary hospital.

Dr. COHEN. Basically we have not had to settle that question because the hospital industry in Maryland is almost entirely nonprofit.

There are three proprietary hospitals, two of which opened during the past year and are currently making startup losses, which is only natural. One of them as a matter of fact had about 23 percent occupancy its first year, and you would hardly expect anyone to make profits when they have that kind of occupancy. As a result we have not come to a conclusion, but we do believe that the 1.5 percent of the Medicaid Trust Fund, for example, is rather arbitrary and is not related to a true market return.

Mr. PIKE. Let's talk about the pay of the administrators of nonproprietary hospitals. What is reasonable there? Who says?

Dr. COHEN. What the commission does is similar in many ways to what Mr. Forand suggested should be done; that is, we have a uniform functional accounting system so we know for every hospital in the State of Maryland what management per equivalent inpatient-day costs; an equivalent inpatient-day is a weighting of inpatient and outpatient activity.

We know in every hospital the management cost per patient-day and we use an 80 percentile level for measuring reasonableness; so

hospital whose management cost per patient-day is above the 80th percentile we challenge. In this way we set a reasonable upper limit.

For purposes of inflation we don't inflate any management; that is the top management salaries. We don't inflate. They get their increases basically through beating the budget; that is, through beating the general inflation system that we use.

Mr. PIKE. Once you started operating, top management salaries essentially were frozen?

Dr. COHEN. That is right, unless they beat their budget. If they performed better than the commission thinks is reasonable for hospitals to perform.

Mr. PIKE. Mr. Chairman, I am going to ask a very basic and perhaps stupid question.

When we talk about prospective reimbursement systems, what are we talking about—just setting the budget of hospitals or the amounts which they can in the future charge, or is there some form of prospective reimbursement?

Dr. COHEN. In our system, in the Maryland system, what we do is we approve as of a particular rate what the rate is that hospitals can charge for patient care activities for an indefinite future period.

Medicare and medicaid do not reimburse hospitals on the basis of our system. They reimburse hospitals on the basis of the traditional cost reimbursement system.

Maryland Blue Cross and GHI, which also does contracts with hospitals in Maryland, do pay according to the commission system.

That is to say, Maryland Blue Cross pays according to the charges the commission establishes in which we give Blue Cross a 4-percent differential for certain activities they do.

Every one else does pay our rates.

Mr. PIKE. What I am leading up to, one of the complaints I have heard from the hospitals, is that far from there being prospective reimbursement, every time they are dealing with third-party payors they have accounts receivable that are just huge, and it adds substantially to their costs.

Dr. COHEN. One of the things I think is very important, that accountants have had too much to say about the way hospitals are reimbursed. Our system does not recognize accounting as the basic mechanism for rate setting; it is more economics, more market oriented.

Working capital, which is one of the things you identified, is distinctly a cost of doing business.

In the commission's system we recognize working capital, that is the cost of factoring your receivables, for example, as a cost element. We calculate the costs otherwise and then add 2 percent for working capital.

The reason we add 2 percent is that the average hospital in Maryland has about a 60-day receivable and the cost of money is about 1 percent per month.

On the other hand, while we add that 2 percent, our rate order says that anyone who pays upon discharge gets a 2-percent discount as they are not contributing to the working capital costs, whereas after the 60 days are up, every 30 days after discount the charges go up 1 percent.

For medicare and medicaid, if they were part of our system, but for Blue Cross actually, for example, if you have a working capital advance to the hospitals which is equal to your average outstanding balance, then mathematically that is equivalent to paying on discharge so that earns you the 2-percent discount.

So, if everyone had an amount at the hospital equal to their receivables, the hospitals would not have a receivable problem, and no one would pay that extra 2 percent.

That is how we handle working capital.

Mr. GRIFFITH. Mr. Pike, these figures, 2 percent and so forth, are true and valid and reasonable arguments from the hospital's point of view, but they don't come anywhere near the 15- and 20-percent increase rates that we have seen in the past several years.

Mr. PIKE. I agree with you completely, Mr. Griffith, but you cited in your statement that you in your area have cut—and I think you used the phrase "hospital costs"—by $60 million.

Are you talking about hospitals costs or what you are paying the hospitals?

Mr. GRIFFITH. We have agreed in Michigan, with a great deal of dissent, as I am sure you can understand, that we will pay hospitals $60 million less than their trend line would have indicated.

It is almost a certainty that hospital expenses will not go up more than that: that is to say, they will live within their budgets.

There are two or three bankrupt hospitals in Michigan. There may be four or five at the end of this calendar year. The State could easily sustain 25 or 30 bankruptcies and would probably be the healthier for it.

Mr. PIKE. So you are not concerned about the increase in the number of bankrupt hospitals because you think you have more than you need?

Mr. GRIFFITH. We have more than we need, and we think the lack of the threat of bankruptcy has caused a mentality that is in fact unhealthy.

Mr. PIKE. Last question, Mr. Chairman.

Did Grand Rapids become the most effective reimbursement system in the State only after Mr. Vander Veen became a Congressman?

Mr. GRIFFITH. Sir, it is a tradition of Dutch thrift.

Mr. VANIK. Thank you, Mr. Pike. Mr. Rangel?

Mr. RANGEL. With the exception of the cost involved, what is the difference in establishing a budget prior to the time that the service is going to be provided and establishing set rules for retroactive reimbursement?

Dr. COHEN. Basically, under the medicaid and medicare and traditionally Blue Cross system of retrospective reimbursement, what hospitals have to prove is not that what they spent was reasonable, although there are now some developments or regulations along that line with medicare, but basically what they have to do is prove that they spent the money.

They don't have to prove it was reasonable to spend the money.

Mr. RANGEL. This could be prospective. Maybe we are talking about the same thing. Notwithstanding the fact that the service was rendered, how can those who are reimbursing not know ahead of time the limitations that are set into place for reimbursement?

Would that be the same as prospective reimbursement?

Dr. COHEN. Do you mean if they were told that retrospectively they will be paid no more than x percent more than they were paid in the previous time?

Mr. RANGEL. Yes.

Dr. COHEN. There is something prospective about that, there is no question about it, but I think the problem is largely with incentives, partly.

That is, if you say the most we are going to pay for you is 7 percent more because you think that is reasonable, and then they spend 5 percent more, do you actually give them 7 percent or do you only give them 5 percent more?

Mr. RANGEL. It is interesting, Mr. Cohen, to read your statement with all of the savings that you had in Baltimore. Is that commission statewide?

Dr. COHEN. Yes.

Mr. RANGEL. Why was Baltimore selected to show?

Dr. COHEN. This is not my data. This is the Bureau of Labor Statistics data. My figures for Maryland show that in Maryland as a whole, hospital rates, as I indicated in my statement, over the 22-month period have increased at an annual rate of 7 percent, and costs are currently increasing at an annual rate of 9 to 10 percent, which is well below the national average.

Indeed, I believe that the BLS is wrong about Baltimore when it says 3.8; I think Baltimore rates went up about 7 percent like everyone else; it is just that they count it differently than we do.

They only count hospitals daily service charges and don't look at all at the revenue and all the rates, which we do.

When I say rates have gone up 7 percent, I mean everything hospitals charge for patient care, not just selected individual daily service charges.

Mr. RANGEL. How do we know what those figures mean?

In New York City when they want to save the cost of medical services, they close the hospitals and lay off the people. How are we to know that is not reflected?

Dr. COHEN. There have been no hospital closings, but let's face it, hospital costs are 70 percent labor, and there is no way you can control hospital costs by making the hamburgers smaller.

The only way to control hospital costs is by cutting down, holding the wage rates of hospital workers into reasonable line with what people outside are making and making hospital workers productive.

Mr. RANGEL. Do hospital workers receive a wage comparable to that of other people providing similar services outside of hospital work?

Dr. COHEN. I think that is a very good question because the main reason why hospital inflation has increased faster than the Consumer Price Index over the past 20 years up until about 3 or maybe 5 years ago, is that hospital workers were catching up to what people outside the industry were earning.

I would submit to you that that catchup has ended; that is to say, they have caught up. We have significant data at the Commission to show that hospital employees in Baltimore and Maryland in general are earning amounts comparable to if not higher than what similarly trained and similarly employed people are earning outside.

For example, the hospital housekeepers, dietary, and laundry workers were on strike in Baltimore when we had sent out a questionnaire, for our own information to all the hotels and motels in the area and found that similar workers were earning $1 an hour less.

That is an awful lot of money.

Mr. RANGEL. How many nonprofessional hospital workers were laid off?

Dr. COHEN. I don't know the difference in numbers between nonprofessional and professional but I would indicate that prior to——

Mr. RANGEL. When you were checking with the hotels, you knew what the comparable work was. You were not talking about managers.

Dr. COHEN. I know what the layoffs in Baltimore have been but I don't know the difference between the professionals and nonprofessionals.

Mr. RANGEL. We will assume that if Baltimore operates the other cities, the professional percentage was very low.

Dr. COHEN. That happens not to be the case.

One Baltimore hospital just laid off more than 100 people, and they gave us a list which includes administrators and several nurses.

There were many people with relatively high incomes there that were laid off.

Mr. RANGEL. Fortunately we are an oversight committee and so perhaps we don't have to get involved in the issue, but in New York if a service costs too much you stop providing it and then you come back and say that that is a saving.

There is absolutely nothing in your statement to reflect whether or not the quality of the medical services rendered was not equivalent to the decrease in the cost of delivery of the medical services.

Dr. COHEN. Mr. Rangel, I think you have struck an extremely important point. I would indicate that there have been five or six hospitals in Baltimore which have had major layoffs since the commission started regulating their costs.

In no case has the medical staff indicated that there have been any decreases in the quality of care.

Mr. RANGEL. Very few people in New York complain when there are layoffs.

Dr. COHEN. I am talking about the medical staff.

Mr. RANGEL. We fire medical staff, too.

Dr. COHEN. The attendant staff which gets the benefits of as many people as the hospitals can hire, even they have not suggested that the hospitals by laying off people have become less efficient.

The only time they——

Mr. RANGEL. When the mayor starts laying off, no one in that department starts complaining except the unions because they cannot be fired.

Dr. COHEN. The union people are being laid off.

Mr. RANGEL. My point is you do not find too many people, who have discretionary contracts and are vulnerable, who are complaining about the quality of services that they are delivering as a result of the cutbacks. Are the doctors paid for by the city?

Dr. COHEN. No; these are physicians who are attending staff, who are bringing their own patients in and billing their own patients separately.

Mr. RANGEL. I see, that is different.

That ends my questioning, Mr. Chairman.

Mr. VANIK. Mr. Stark.

Mr. STARK. No questions.

Mr. VANIK. I would like to ask the panel what happens if and when a hospital does not meet its target budget? Are we then back to retrospective reimbursements?

Mr. FORAND. We had several examples last year where that happened, where a hospital overspent its budget and then tried to build its new budget on an inflated base which exceeded what we had approved.

As a result and in order to assure that hospital budgets were limited to the Maxicap for the second year, which was 11.5 percent, we had to cut some hospitals back to levels which in some cases ran as low as 7 percent for total operating expenses this year. So, in effect, some hospitals were penalized as a result of overspending their budgets because their increment for the subsequent year was reduced.

Mr. VANIK. If a hospital exceeds its budget, for example, runs out of money by Thanksgiving, what alternative does the public have?

Go ahead.

Mr. GRIFFITH. Mr. Vanik, the hospital is highly unlikely to run out of money by Thanksgiving. It has essentially the same kind of opportunities open to it that the local food store has if it has to pay more than it is able to get selling its food. It has cash flow from depreciation to live on, it has the opportunity to cut back during the year to avoid getting into a problem at Thanksgiving time, and it has an expert staff of managers in most cases who, despite the criticism they receive, are quite capable of forecasting the total economic operation of the hospital to within half a percent.

Mr. VANIK. If prospective reimbursement systems contain costs by setting lower per diem rates, how can you prevent hospitals from obtaining excessive reimbursement by lengthening the period of stay beyond what may be necessary?

Mr. FORAND. That is the point I made when I said we ought to approve the total operating expense budget of a hospital including volume, for example patient days. If you don't include the total budget, and limit your approval to per-diem rates, then the hospital has an incentive to increase the length of stay.

Dr. COHEN. You have to judge the reasonableness of the budget on the case-mix, of adjusted lengths of stay. That is very important.

Mr. VANIK. In Michigan, where the large automobile unions are the buyers and set the limits, do the providers charge individuals for any extra charges?

Mr. GRIFFITH. No, sir. The Michigan Blue Cross contract would not permit them to charge the individual.

Mr. STARK. I am just curious about some things in terms of occupancy rates. Generally you are talking, I guess, about Michigan and Maryland. Is there a vacancy rate or an occupancy rate that you find throughout the States?

Mr. GRIFFITH. In Michigan it would be possible to either reduce the bed supplier or increase the use of hospitals by about 5 percent by improving——

Mr. STARK. Including on a 7-day week you are running about 95 percent full?

Mr. GRIFFITH. I am talking about the difference between where they are now and what is technically and practically achievable. Michigan is a relatively high-occupancy State, about 80 percent occupied. We believe, and my bureau has done specific research on this question, that they could achieve 85 percent, perhaps a little higher, but not over 90 for sure. There are certain reasons they have to——

Dr. COHEN. We are in a very similar position. We feel that there are too many beds in the State; maybe we are not as over-bedded as Michigan, but there is no question that there are selected hospitals which have very serious excess capacity problems.

Mr. FORAND. Another problem, I think, is it depends on the service. For instance, in Rhode Island most of the medical surgical occupancy levels are 90 percent or higher, but if you look at obstetrics and pediatrics, you find occupancy levels as low as 25 or 30 percent.

Mr. STARK. Is a hospital prohibited from changing its mix? I mean, could you convert one to the other?

Dr. COHEN. In Maryland you have to go through the licensing and regulation people.

Mr. STARK. Is it practical?

Mr. GRIFFITH. It is often impractical, yes.

Mr. STARK. One assumes that at some occupancy level everything above that is gravy, given fixed staffing and fixed costs. Is there any elasticity in pricing? Does anybody offer cut rates for coming in on weekends, or can the hospital that has an occupancy problem offer 3 days for the price of 2?

Dr. COHEN. We don't do that, although often in our system we do have an admissions charge which catches the very short stay patients with some of the costs of having to set up his bill, his medical record, et cetera. We have had several hospitals go out of the pediatric business and the obstetric business because we have set rates based upon what their costs would be if they were effectively utilized. If they could not achieve that effective utilization, we have said, OK, you have certain allocated fixed costs; we will pick those up in the other areas and that will help the other hospitals, too, which have very bad OB and pediatrics.

One thing, when you get into this, you almost always hear "If we go out of our OB"—there is a domino theory we have, that if we go out of OB, we will lose our gynecology business and then our mixed surgery business and everyone goes. There are three hospitals in Maryland that have gone out of the OB business in the past year and every one has more gynecological business than they had before they went out of OB. So there is no question in my mind that that is just a red herring.

Mr. STARK. OB can change to the general surgery. It is kind of hard, I suppose, for pediatrics to handle it when you have short beds to handle some adult-type problems.

Thank you.

Mr. VANIK. I would like to ask the panel, how would you categorize the SSA support of the prospective reimbursement experiments?

Dr. COHEN. Speaking for Maryland, their support to us, as I mentioned, has been in the development of our methodology. I think their dollars were invaluable there. I think they obtained about half a million dollars worth at least for the $200,000 they gave us.

Mr. VANIK. The benefit-cost ratio was very high?

Dr. COHEN. Yes; to them. I think I would like to see more willingness on their part to join in the experiment paying rates. I think they are starting to evidence that.

Mr. FORAND. We were one of a couple of States in the country which received an exception from the medicare cost principles. In the experiment, we entered into a cost-sharing arrangement with SSA over the 3-year period in which SSA agreed to pick up half the costs of the State and Blue Cross participation, SSA personnel participating in the staff discussions and providing staff expertise relative to negotiation of the Maxicap.

So I would say that overall the relationships between SSA, the State, and Blue Cross have been very good.

Dr. COHEN. Excuse me, Mr. Vanik, if I might. I might indicate that our law says we have to review hospitals individually and we have public hearings on individual hospitals' budgets. I have invited, for example——

Mr. VANIK. Does the public participate?

Dr. COHEN. We hope some do.

Of those we have invited, for example, Legal Aid of Baltimore does and Blue Cross of Maryland does. We have invited medicare and medicaid, even if they are not going to pay our rates, to come and help represent patients, to question the budget.

That they have not done. I think that is not appropriate. I think even though they didn't know whether we could recognize them, they still, as a free rider, paying achieved costs, would be benefited and the public would be benefited by their taking part in those hearings, and I hope they will do that even before they agree to pay our rates.

You have mentioned what goes on in regulatory agencies. Before I joined this industry, I taught regulation. I think one of the main things this industry has going for it is at least the possibility that consumers will be represented in organized form by medicare, medicaid, Blue Cross, et cetera, whereas consumers are not represented by anyone before the CAB, for example.

Mr. VANIK. Thank you very much.

Mr. Griffith?

Mr. GRIFFITH. Mr. Chairman, in Michigan there was an effort made by the State legislature last year to impose a freeze which was similar in intent to the Blue Cross action on medicaid, and suit was brought by the hospitals. The social service has dropped their freeze because they don't feel the suit is defensible under the current social security legislation.

I believe that should be corrected. I believe that the State should be free to do that kind of thing, and medicare and BHI should be free to do that kind of thing.

Mr. VANIK. Through modification of the statute?

Mr. GRIFFITH. Yes, sir, and whatever other encouragement is necessary.

Mr. VANIK. Now, Mr. Smith, we are very happy you are here with us. I was going to suggest this: Your statement can be considered as read and inserted in the record. You may read it in full or you may summarize it.

You have some very good data on health inflation which we are glad to have. So you may proceed in whatever manner you want.

STATEMENT OF ELMER W. SMITH, ASSOCIATE COMMISSIONER FOR POLICY AND PLANNING, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY CLIFTON GAUS, DIRECTOR, DIVISION OF HEALTH INSURANCE STUDIES, OFFICE OF RESEARCH AND STATISTICS, AND MELVIN BLUMENTHAL, DEPUTY DIRECTOR OF POLICY, BUREAU OF HEALTH INSURANCE

Mr. SMITH. Thank you, Mr. Chairman.

I will speak to some highlights with the understanding that the statement will appear in the hearing transcript. I would like to note that accompanying me today are Dr. Clifton Gaus of our Division of Health Insurance Studies of our Office of Research and Statistics, which is the part of the Social Security Administration most directly concerned with the administration of these experimental projects on prospective reimbursement; and also Mr. Melvin Blumenthal, who is the Deputy Director for Policy of the Bureau of Health Insurance, which administers the title XVIII program.

I would like to do two things, if I may. One is place the subject of prospective reimbursements in some perspective as it relates to the control of health care costs; and, second, as the committee had suggested, indicate what we have learned thus far, with the caveat or caution that, of course, we are only initially into prospective reimbursement experiments, so any conclusions we have are highly tentative.

However, our conclusions are very consistent with the judgments of the members of the panel who have just testified.

Let me note that the problem of spiraling health care costs is probably one of the most intractable problems in this country today and I think it is recognized by the fact that Congress has enacted so many different pieces of legislation trying to get at this question from quite different parts of the health care delivery system, from the financing structure, and from the question of supply of personnel to provide health care services.

To note just a few, look at the Health Maintenance Organization authority administered by the Public Health Service in HEW, which is attempting to work on prepaid capitated systems which affect both the organization of health care services as well as the ways they are financed; look at the National Health Planning and Resources Development Act, which is more focused on the question of what are the needs for facilities and services and how should they be distributed and regulated among States and substate regions; and look at the Professional Standards Review Organizations, which are attempting to look at this question of utilization—are lengths of stay too long and are the kinds of services being provided appropriate or not.

If we look at the national programs for the support of training physicians, nurses, and physician extenders, if we look at the efforts to develop alternative care packages for the support of home health care services and day hospitals and a number of other activities which are going on at the present time, if we look at the President's proposals to put a cap on increases in medicare reimbursements of 7 percent for hospital services and 4 percent for physicians' services, if we look at the experience of the economic stabilization programs in 1972–

73 which attempted a similar regulatory effort to put a cap on increases in costs, we can see that all of these are efforts to try to constrain health care costs and it is obvious they all have a contribution to make. At the same time we are still experiencing the spiral in these costs, so the Congress has tried and the executive branch has tried in a variety of ways to grab hold of this beast, but it is obviously a very difficult problem.

This subcommittee has already received testimony, both today and at sessions previously this year, on the question of what is it that is driving costs up? Obviously there are a variety of factors and I will name just a few.

One is, of course, the introduction of new products and medical technology—new brain scan equipment, cobalt therapy devices and equipment and so forth. Obviously this is very expensive, and these elements are being introduced constantly into the health care delivery system.

Another is the question of capital costs. Mr. Cohen was speaking about the opening of some new hospitals in Maryland. There are new costs.

We have the increasing salary, wage and professional fee costs. Again this is a very labor-intensive industry and these are very important.

We have the question of greater per-capita utilization of health care services, which we are experiencing.

These are just a few of the factors. Therefore, the question of how one controls or constrains health care costs would have to presumably move along a variety of lines, not just one single line or one single device.

Now I don't mean by that statement to suggest that there is no rule to be played by the prospective reimbursement or prospective budgeting technique, but I merely stated this to put in perspective that it alone probably cannot totally solve the problem of increasing health care costs.

We have looked at what is being done at the present time and have some conclusions or some learnings from the experiments that others have conducted before the medicare program began to participate in the experiments. We have also been learning from the projects in which we have been participating. We think there are several key elements which have come to the fore. These have generally been mentioned by the other members of the panel.

One is that it is very important in these systems to have uniform accounting, budgeting, and recording systems so that you can, in fact, make comparisons and deal with the understanding that you are treating like things in a similar manner within the framework of your prospective budgeting system.

Another is the importance of coordinating to the maximum extent possible health planning authorities and agencies with ratesetting authorities and agencies. This can be done a variety of ways. The new National Health Planning and Resources Development Act suggests a model where there is a total integration of the ratesetting and health planning authorities so that questions of issuing certificates of need for expansion of existing facilities or for establishment of services

will be considered by the same agency which is also establishing the rates.

In other instances the ratesetting and the health planning authorities can be separate organizationally, but obviously there has to be close coordination either within the State or locally between those two authorities and the activities that they are undertaking. It would be senseless for one part of the official establishment to be authorizing essentially tremendous expansion while another was trying to hold down costs on the ground that perhaps some of this either was not needed or, in any event, was certainly helping to fuel the fires of inflationary increases.

Third, we believe that the focus should be on total costs of the hospitals rather than just per-diem costs. We have found, for example, in one of the experiments in New York State that when there are tight controls on per-diem costs—again, and I think this is only reasonable in some respects on the part of hospital administrators and those who provide the service—there is a tendency to expand the length of stay in order to spread those costs out; so, the reductions in total costs in the New York experiments, although there was some constraint, were not as great as the reductions in the per-diem costs because some of it was caught up by the increasing lengths of stay.

So the focus should be on total costs and not just on per-diem costs. Then I think we have come, perhaps slowly, but nevertheless we have come to a point where we agree again with the panel members that to the maximum extent possible our participation in the prospective reimbursement experiments should be in a setting where basically all major financiers are included within the system. That is, Blue Cross, the commercial insurers, medicare and medicaid should to the maximum extent possible be participating in the same system. Otherwise you do get the shifting, as Mr. Forand pointed out, or attempted shifting from one financier to another.

Finally, we would say that, although they have had apparently very fine experiences in Rhode Island in getting voluntary participation in their Maxicap system, the evidence would seem to point to the fact that these systems generally across the country are not going to work unless there is mandatory participation required of the providers. Otherwise, if you do not have this mandatory participation, you will get a degree of what in insurance terms is called adverse selection, that is, these people who will benefit in some way or other are going to opt in, and those who will not are going to opt out, and I think we have seen in at least one experiment in the State of Connecticut that, in fact, was the case.

I think that at this stage I would just ask the subcommittee if it has any questions. We would be glad to go along any particular line in which your questions would lead us.

[The prepared statement follows:]

STATEMENT OF ELMER W. SMITH, ASSOCIATE COMMISSIONER, POLICY AND PLANNING, SOCIAL SECURITY ADMINISTRATION

Mr. Chairman, members of the subcommittee, thank you for the opportunity to testify on the status of Medicare research and demonstration projects in the field of prospective reimbursement for hospital services.

The emphasis on prospective reimbursement experimentation in recent years has been a response to the unprecedented escalation in health care costs which

has occurred over the last decade or so. Health expenditures were just slightly over $38.9 billion in 1965, accounting for 5.9 percent of the gross national product. By 1975 the Nation's health bill had reached $118.5 billion, or 8.3 percent of the gross national product. In spite of regulatory and other efforts (such as imposition of the Economic Stabilization Program controls), medical care prices have continued to rise at rates well in excess of the overall cost of living. For the calendar year just ended, the medical care component of the Consumer Price Index increased by 10 percent versus a 7 percent increase in the general CPI.

Health care costs are rising even faster for the aged and the disabled. For example, in fiscal year 1975, health expenditures for persons age 65 and over rose 18 percent, as compared with an 11.4 percent increase in 1974. The effects of these rising medical care prices on Medicare outlays alone are quite apparent and disturbing. By fiscal year 1977, Medicare outlays are expected to exceed $21.9 billion—a $4.2 billion increase over fiscal year 1976 expenditures.

Although prices are rising in every area of the health care industry, it is clear that expenditures for hospital care account for the largest share of costs, and that these costs show the greatest percentage increase from year to year. Roughly 40 percent of all personal health care expenditures are for hospital care, and within the Medicaid program such expenditures constitute 75 percent of total program costs. In fiscal year 1975 alone, hospital semi-private room charges increased by 16.4 percent.

Previous testimony before this Subcommittee has indicated that the driving forces behind the cost increases in this area are the introduction of new and more sophisticated medical technology, greater per capita utilization of services, the ever-rising cost for the professional, paraprofessional, blue collar, and clerical staffs of hospitals; capital expenditures; and similar factors. Thus, no single approach in and of itself is likely to be wholly effective in constraining health care costs. Instead, a truly effective cost-containment system must include a combination of reimbursement approaches—for example, strengthened planning and "certificate of need" processes, adoption of more uniform accounting and reporting systems, and improved rate-setting mechanisms. Experimentation with these and other reimbursement approaches is, of course, a particularly valuable and promising area of research.

As provided in the original Medicare legisaltion, reimbursement to hospitals and other providers is made on the basis of "reasonable costs." These costs are determined on a retrospective basis by application of complex formulae to prior-year cost reports. The formulae take into account costs attributable to services provided to Medicare beneficiaries, including costs for plant and equipment, labor, supplies, etc.

Not long after the Medicare program was implemented, Congress recognized the need to experiment with other methods of reimbursement as possible alternatives to the "reasonable cost" concept. Under section 402 of the Social Security Amendments of 1967, the Congress authorized experiments with various incentive reimbursement approaches. These experiments involved a variety of attempts to stimulate and encourage hospitals to economize in their expenditures. The main problems with the incentive reimbursement approach were that hospitals participated on a voluntary basis and that incentive payments and penalties were assessed retrospectively. Under these conditions, hospitals which expected to benefit under the experiments stayed in the experiment, while those who expected penalties dropped out. Thus, the incentive systems had very little influence on the behavior of administrators, physicians, and others providing services in hospitals.

The Congress later amended title XVIII to provide for prospective reimbursement demonstrations under section 222 of the Social Security Amendments of 1972. An impetus to the granting of this authority was the fact that a great deal of experimentation in this area was going on without Federal involvement. Consequently, before the Social Security Administration embarked upon its own experiments, it decided to review systems already in place in order to determine where it should concentrate Medicare resources.

To place the Medicare experiments in perspective I should note that there are currently 26 prospective reimbursement systems in existence in 22 States. These systems are fairly substantial, involving about 25 percent of the Nation's hospitals. These systems also take a variety of forms. Eight States have established public rate-setting authority which approve prospective rates and review requests for modification of those rates. In three of these States special commissions have been specifically organized to perform these functions. In the remaining five, this

same power is vested in previously existing public agencies such as State health departments.

In addition to the eight State review systems, 16 of the 74 Blue Cross plans are sponsoring prospective reimbursement systems. In two States such systems operate along with State programs. In two other States, non-profit corporations have been established under the sponsorship of State hospital associations to set prospective rates on a voluntary basis.

As you can see prospective reimbursement systems vary in their political, organizational, technical, and regulatory aspects. A generic definition which could cover all of these systems is that prospective reimbursement is a process which establishes the rate of payment in advance of the period for which the rate is paid.

Generally an attempt is made in establishing these prospective rates to build in either incentives which encourage more economical practice on the part of providers or at a minimum to constrain provider cost increases below that which would otherwise be obtained. In either case, the system includes risk factors—namely, if the provider spends less than the prospectively set rate it keeps all or part of the savings, or if its costs exceed the rate, it will have to absorb the loss.

Since SSA entered a field in which a great deal of effort was already underway, it decided to proceed on a step-by-step basis. First we decided to find out specifically what was already happening in the field. A contract was let with the Harvard University to develop descriptive case studies of 11 operating prospective reimbursement systems. These case studies broadened our understanding of prospective reimbursement and provided the groundwork for specific developmental and demonstration projects. The summaries of these case studies have been widely distributed to individuals, legislators, organizations, and others interested in cost containment. Copies also have been provided the Subcommittee staff.

The second step we took was to evaluate more intensively seven existing prospective reimbursement systems. These evaluations included systems operating in western Pennsylvania, upstate New York, downstate New York, New Jersey, Rhode Island, Indiana, and Michigan. Reports have been received on five of these evaluations. Results from Indiana and Michigan will not be available until the end of this calendar year.

These evaluations were conducted by outside experts and involved complex economic and statistical methodology. The results of all the evaluations point in the same direction. That is, prospective reimbursement systems seem to slow the increase in costs, but some systems are more effective in constraining health care costs than others and the impact is not always the same in each hospital. In addition, the amount of savings that can be attributed to prospective reimbursement in these cases is small relative to the trend in total increases.

Some systems, for example that of Blue Cross of Western Pennsylvania, are complicated and expensive to operate for only a few hospitals so that the benefits obtained were in part outweighed by the cost and complexity of the system itself. When expanded to more hospitals, such a system might prove cost effective. Other systems, for example in New Jersey and Rhode Island, constrained costs below levels which would otherwise have been achieved but only by small margins. One particularly interesting element is that the system used in New York State, which does not depend upon budget reviews but instead upon a formula which updates base year costs with a trend factor related to general economy inflation factors, achieved different results in upstate New York than it did from downstate New York. Since the New York system was operated by many different Blue Cross plans within the State, there is some suggestion that the administration of the system may importantly impact on the question of cost constraints. In upstate New York there were relatively minor savings experienced, that is, less than 1 percent per year, but in downstate New York the system produced more significant savings in costs per day and costs per case.

Overall, then, we can say that prospective reimbursement systems generally exert a modest downward effect on hospital costs and that some systems, such as those in New York, can be more effective in achieving this result than others. In the area of quality, there was no evidence from any of the evaluators that prospective reimbursement had caused any discernible deterioration in the quality of care. One qualification should be mentioned in all of these findings. Since the number of hospitals and reductions in cost levels are small in most cases, the results do not always pass rigorous statistical tests for significance, and thus our findings must be interpreted with caution. This also points up the need for additional evaluations and improved evaluation methodologies.

Against this backdrop, SSA, of course, has continued to experiment with other reimbursement systems. Therefore the third step we took was to participate in actual demonstration projects. Medicare is currently paying prospective rates in three such projects. These include an expansion of the budget review program administered by Blue Cross of Western Pennsylvania, a single system is South Carolina which combines budget review, management engineering and financial planning, and a program in Rhode Island which establishes a statewide "maxi cap" limitation on allowable increases in total hospital operating costs.

In all three projects, SSA has participated by covering part of the administrative costs as well as waiving Medicare principles of reimbursement which otherwise control reimbursement under Title XVIII. Furthermore, Social Security is proceeding under both the section 222 authority as well as section 1526 of the Public Health Service Act (as amended by the National Health Planning and Resources Development Act of 1974) to experiment with participation in Statewide rate setting models. The first of these projects involves participation with the Maryland Health Services Cost Review Commission. The thrust of this particular demonstration is to provide across-the-board participation with other third-party payers in a mandatory State rating-setting effort. The Social Security Administration is continuing to support developmental efforts to strengthen this system and anticipates paying for at least one year of prospective rates established by the Commission, once they are operating Statewide.

In addition, we have 14 proposals currently under consideration. These proposals were all developed as a response to a special project invitation in September 1975, based on over a year of developmental work in SSA. We solicited proposals from prospecitve reimbursement systems already under way, or from States and organizations interested in developing prospective rate-setting systems. In January we received five proposals offering to implement prospective rate-setting systems and nine proposals to develop such systems. These are now under review for technical acceptability, and we hope to be able to fund a number of these projects by September 30 of this year.

As I had indicated earlier, approaches to constraint of health care costs must take a variety of routes. In addition to the specific proposals that we are preparing to fund, we have been working on a number of other techniques and procedures to assist insurers and providers to contain health care costs. The first of these is the development of uniform accounting and statistical systems required by section 1533(d) of the Public Health Service Act. Both under contract and with our own staff we are completing a uniform chart of accounts which will soon be sent to providers in the field for comment. We are also currently at work on the development of a uniform classification system for health care providers and a statistical and financial reporting system for those providers.

Time does not permit me to discuss all of the projects we have under way in prospective reimbursement. In total, we expect to have in place over $10 million of prospective reimbursement projects by September 30.

In fiscal year 1977, the President's budget will permit a step-up of these activities. Funds would be used both from the Medicare trust funds for these projects and also from general revenue appropriations which have been requested to specifically fund projects authorized under sections 1526 and 1533(d) of the Public Health Service Act. This latter act authorizes the participation in models which combine rate setting functions and health planning functions in the same State agency. We feel this authority is particularly important because it recognizes the important role of health planning to rate regulation and cost control.

Although our efforts to participate in prospective reimbursement systems are only partially under way, we already believe that there are certain lessons we have learned. Drawing from our evaluations and ongoing demonstrations and experiments, we believe that there are at least five elements which are critical to the successful operation of an effective and equitable prospective rate setting system.

First, it is necessary for hospitals in any rate setting system to submit uniform budget and accounting information for the period for which the prospective rates are to be set. Second, any system should coordinate health planning and rate setting functions, be it through agreements of the respective organizations or through an integrated organizational model such as envisioned under the National Health Planning and Resources Development Act.

The third critical element is to ensure that a prospective payment system focuses not only on per diem cost but rather on total hospital expenditures,

including utilization factors. We have found that only a slight increase in hospital utilization can offset the entire economies from reducing per diem costs. Fourth, we believe that prospective payment systems will not be fully viable unless they include all payers. This means that wherever possible we are encouraging and participating in prospective payment systems that include other third-party payers such as Medicaid, Blue Cross, and commercial insurers. Finally, our experience has taught us that significant cost savings in hospitals will not come about on purely a voluntary basis. Thus any system of the future will need to be mandatory in some degree. We are exploring a number of alternatives here, short of a complete Federal or State takeover of the rate-setting function.

In conclusion, we think that we are learning much that will guide future legislative decisions in this area, but do not believe our R&D effort has produced enough information yet to recommend at this time a specific model or models for general adoption.

In the interim, however, we believe that the potential impact of prospective reimbursement systems is sufficiently great that it does warrant increased and continued investment of Federal dollars for R&D. We welcome the interest of Congress, and are prepared to discuss any questions you may have to the best of our ability.

Accompanying me today is Dr. Clifton Gaus, who is the Director of the Division of Health Insurance Studies of our Office of Research and Statistics. Dr. Gaus and his staff are directly involved in the development, review, and monitoring or our experimental and demonstration projects in the area of prospective reimbursement systems. Both of us are available to answer your questions.

Mr. VANIK. In your full statement, on page 5, you talk about the 26 prospective reimbursement systems in existence. How many are financed by SSA or HEW?

Dr. GAUS. I don't have the precise numbers, but I would estimate we are participating with actual reimbursement in three of those. We are providing financial support to improve the systems, but not yet paying in those systems, in I would estimate, another two or three. Most of these 26 systems were established some time before our program had really begun to grow.

Mr. VANIK. You talk about the eight States which have established a public ratesetting authority. Are those operational or in planning?

Dr. GAUS. Not all of them are operational. In fact, I think only about half of them are operational. We have recently asked the Governors of all of the States, in fact, not only those that have systems but where the States are planning to develop systems, to submit proposals to us, both operational proposals and developmental proposals.

We have received proposals from three States to go operational—three States that are, in fact, now, or within 6 months will be operational. That is in addition to Maryland, which was submitted to us earlier.

Mr. VANIK. Doctor, you also said in the 8 States' review systems, 16 of the 74 Blue Cross plans are sponsoring prospective reimbursement systems, and you say in 2 other States nonprofit corporations have been established to set prospective rates on a voluntary basis.

Now, what good is that?

Dr. GAUS. As I think Mr. Smith indicated, we are cautious about those, and the voluntary plans, we think, have not shown the significant types of savings that those plans which contain some mandatory elements have shown.

The only voluntary ones that we are participating in are western Pennsylvania and South Carolina at this point, in addition to Rhode Island. Our plans are not to expand greatly our activities in that area. We are looking more toward the mandatory-type systems to experiment with.

Mr. VANIK. If 25 percent of the hospitals are using some form of prospective reimbursements, why is there still so much inflation?

Dr. GAUS. I think that is in part because a number of those systems are voluntary, a number of the systems are in the very early years of development, and it is a rather new concept. Most of these systems were established in the last 3 or 4 years, with the exception of a very few that have been operating for 10 years or so.

Mr. VANIK. On page 7, you talk about the contract that was made with Harvard University. Can you tell us when that was made?

Dr. GAUS. It was made approximately 3 years ago. I can give you an exact date on that.

Mr. VANIK. That is close enough.

Dr. GAUS. It was approximately 3 years ago.

Mr. VANIK. The point I am making is that it was 1½ years after the amendments were passed, and that is one of the lags that concerns us as we look over the program.

On page 8 you talk about taking a second step to evaluate more intensively seven existing prospective reimbursement systems. Again my question is, beginning when?

Dr. GAUS. About 22 months ago, and they are now in their completion stages. In fact, all of them are, and we didn't cover that in the oral testimony. In the written statement we do have some results from those evaluations.

Mr. SMITH. You are suggesting a summary statement of the summary evaluations for each project?

Mr. VANIK. Yes, I think we ought to have that because of our concern.

[Summary statement requested follows:]

RESULTS OF HOSPITAL PROSPECTIVE REIMBURSEMENT IN THE UNITED STATES

(By Clifton R. Gaus and Fred J. Hellinger, Division of Health Insurance Studies, Office of Research and Statistics, Social Security Administration)

(Studies were conducted in western Pennsylvania, New Jersey, Rhode Island, Indiana, Michigan, upstate New York and downstate New York. Results of the studies in five of the seven systems are shown below. The Michigan and Indiana studies will not be concluded until the end of calendar year 1976.)

METHODOLOGIES

The primary concern of the evaluations was to determine the impact of the prospective payment system on the cost of hospital care. In order to determine the effectiveness of a prospective payment system, we must know what would have been the behavior of hospitals in the absence of a prospective rate system. There are two procedures which may be used to isolate and estimate the effect of prospective reimbursement: First, we may compare for a single State the rate of increase of hospital costs before and after the implementation of a prospective rate experiment; and second, we may compare the rate of increase of hospital costs in a State with a prospective rate system (experimental group) with the rates of increase in comparable hospitals in a State lacking a prospective rate system (a control group).

Both of these methods have drawbacks. The "before and after" approach does not consider the effects of factors other than the prospective payment system which may have changed during the period. For example, if a prospective payment system were operational during the same period as the Economic Stabilization Program, it would not be possible to separate the differential impacts of each program through a time-series analysis of data obtained from a single State even though the data included observations from before and after the implementation of the prospective rate program. In each State under study the

prospective rate experiment was operational during the same interval of time as the Economic Stabilization Program (ESP). Consequently, it is necessary to compare hospitals from different States in order to control for the existence of the wage and price controls.

Interstate comparisons between hospitals, however, implicitly assume that the different States possess comparable environments. Since the control groups in these evaluations are used to illustrate what would have occurred in the experimental group in the absence of a prospective rate program, it is important to select control hospitals in a State which has similar market characteristics and similar standards for medical practice. Each evaluator selected a control group of hospitals and employed both an interstate analysis using data from the experimental and control areas and a "before and after" study of data from the experimental State.

Cost function analysis was used to isolate and estimate the impact of prospective reimbursement in both regressions involving single State time-series data (before and after analysis) and in regressions which included data from the prospective reimbursement State and control State. The use of cost function analysis allowed us to control for factors other than the reimbursement mechanism which effect hospital costs (e.g., output levels, casemix intensity, occupancy rate, etc.). Several evaluators accounted for the existence of a prospective reimbursement program through the inclusion among the independent variables of a prospective reimbursement dichotomous variable. The prospective reimbursement variable was set equal to 1 for hospitals which participated in the experiment and 0 for those not in the prospective reimbursement system. An alternative measure of prospective reimbursement employed in three evaluations was to represent the influence of prospective reimbursement through a variable measuring the proportion of the revenue received by a hospital which is subject to the prospective rate. In most experiments, the prospective rate was applicable to Blue Cross and Medicaid patients. Medicare continued to reimburse on the basis of costs in all areas and commercial insurers paid charges usually outside the control of the prospective reimbursement system.

EMPIRICAL RESULTS

The presentation of the empirical results of each evaluation will be preceded by a brief description of the organization and scope of the prospective reimbursement programs under evaluation.

WESTERN PENNSYLVANIA

The Blue Cross of Western Pennsylvania (BCWP) has initiated and participated in numerous innovative experiments in the field of reimbursement during the past 25 years. Beginning in 1950, the BCWP categories hospitals in order to maximum limits for per diem reimbursements. The involvement and commitment of the BCWP to experimentation with new payment mechanisms was exemplified by the implementation in July 1971 of a prospective payment experiment. Five hospitals from rural Western Pennsylvania, one of which is a rehabilitation center, volunteered for the experiment. In July 1974, the system was included as an option for all Western Pennsylvania hospitals and 11 hospitals entered the experiment.

The approved per diem rate for each hospital is derived by the BCWP from data for the current and the base year. (The base year is two years before the year of the prospective rate and one year before the current year.) Initially, expenses for the base year are divided into operating and non-operating expenses because the formula restrictions apply solely to operating expenses. Base year operating expenses are divided into three categories: (1) general operations—routine services, (2) general inpatient care—ancillary services, and (3) other expenses including outpatient services.

In order to derive the allowable current year operating expenses, the base year general operations expenses per bed, general inpatient care expenses per day, and other expenses are compared with the corresponding values for these categories for the current year. The allowable current year operating expenses are determined using the lower of the hospital's or the composite rate of change for each category. The composite rate of change for this step is the average rate of change for the hospital over the past three years plus the average rate of change for the hospital's group divided by two. (Hospitals are assigned to a group by the BCWP according to their location, teaching status, and bed size.)

After determining the allowable current year operating expenses, these expenses are divided into 7 natural expense categories (salaries, fees, food, drugs, utilities, maintenance, and other). The budgeted per diem value for each of these 7 categories is compared to an estimate of each category's expense derived by applying the expected inflation rate obtained from data from the Bureau of Labor Statistics (BLS). And, again, the allowable rate of increase is determined by using the lower of the hospital's or the composite rate of change for each category. The composite rate for this calculation is obtained by adding the budgeted increase for each category and the expected increase due to inflation and dividing by two.

The approved per diem rate is obtained by summing the approved operating per diem rate and the approved non-operating per diem rate (non-operating expenses are reviewed and approved by the BCWP, but not subject to any maximum formula.) In addition, total hospital expenditures are adjusted retroactively. Total reimbursement is limited based on a comparison of the hospital's per diem cost to that of its group. The maximum reimbursable cost per patient day for each hospital is set at a level which is 12 percent above the group mean cost per patient day.

The evaluators analyzed data from fiscal years 1971–74 and concluded that the five hospitals which participated in the experiment registered smaller increases in non-physician dominated departments (e.g., operation of plant, maintenance, dietary, laundry and linen) than the control hospitals [Applied Management Sciences, 1975]. The ten control hospitals were selected from Western Pennsylvania on the basis of the population in a county living in a rural area, complexity of services, bed size, percent occupancy, ownership, and the existence of teaching programs. The cost of operating the non-physician dominated departments (general service departments) increased 75 percent for the control hospitals and 52 percent for the prospectively reimbursed hospitals during the period between 1971 and 1974. In addition, there was no percentible difference between the rate of increase in costs for the ancillary departments between the control and the experimental hospitals. The evaluators concluded from this observation that hospital administrators when faced with the need to control expenditures, were reluctant to implement these cuts in the ancillary departments which they felt were important in keeping and attracting physicians.

NEW JERSEY

New Jersey was among the first States to limit reimbursement paid to hospitals. In 1958, through the authority granted in the 1938 Blue Cross enabling act, the Commissioner of Insurance imposed ceilings on Blue Cross rates of payment. Hospitals were able to appeal for an exception to an Advisory Committee whose members were appointed by the Commissioner of Insurance. In 1971, the New Jersey legislature passed the Health Care Facilities Act, with the objective of establishing an administrative and regulatory structure to insure the provision of high quality care at reasonable costs. The law resulted in a mandatory prospective rate system where the gathering, preparation, and analysis of the hospital budgets were performed by staff members of the Hospital Research and Educational Trust (HRET) which is a subsidiary corporation of the New Jersey Hospital Association. The Advisory Committee to the Commissioner of Insurance was given the responsibility of reviewing, before final approval, per diem rates for Blue Cross and State supported patients. To assist their decision-making process, the Advisory Committee relied almost entirely on information and analysis provided by HRET staff concerning the reasonableness of each budget.

Due partly to the publication of Bureaucratic Malpractice (7974), a study produced by the Center for Analysis of Public Issues attacking the role of HRET in the budget review process, the information and analysis for the Advisory Committee are now provided by State employees of the Department of Health. The new system has been in operation since the summer of 1974 and was not analyzed by the evaluator because of the unavailability of data from this period at the time of the evaluation.

The evaluators of the New Jersey prospective rate system concluded that there was no statistically significant relationship between prospective reimbursement and costs, productivity, or quality [Geomet, Inc., 1974]. Although the coefficient of the prospective reimbursement variable was insignificant in the estimated cost functions, it was negative. The size of the negative coefficient suggested that the prospective rate program in New Jersey was associated with cost levels 2 to 3 percent per year lower for a patient day of care than would have been ex-

perienced in the absence of a prospective rate program. These results were robust across a wide variety of linear and log-linear specifications of the cost functions which included pooled time-series, cross-section regressions (hospitals in the Philadelphia area were used as a control group) ; lagged adjustment models of pooled time-series, cross-section regressions, and individual year regressions of the New Jersey and control hospitals

RHODE ISLAND

The Director of Business Regulation in Rhode Island regulates Blue Cross rates. In 1970, the hospitals in Rhode Island presented budgets to the Blue Cross plan which, if implemented, would necessitate a 40-percent increase in Blue Cross rates. Under sustained pressure from the public and the media, the Blue Cross plan asked each member hospital to decrease their proposed expenditures by 3 percent to an overall rate of 15 percent. The Hospital Association of Rhode Island (HARI) refused to limit planned expenditures and was prepared to help each hospital defend its budget in public hearings. Eventually, however, after bitter attacks from the public and media, the hospitals agreed to guarantee rates at a level which resulted in a 15-percent increase in revenues. Rhode Island Hospital, the State's largest and most prestigious institution, however, arrived at a different arrangement with Blue Cross which included a negotiated budget and a prospective rate for fiscal year 1971.

The budget review process which was developed by Rhode Island Hospital and the Rhode Island Blue Cross Association for fiscal year 1971 was adopted by the Hospital Association of Rhode Island and the Blue Cross plan for implementation for fiscal year 1972 for all Rhode Island hospitals. The program was operational for fiscal year 1972 for all hospitals, but was discontinued for fiscal year 1973 because of complications arising from the simultaneous operation of the Economic Stabilization Program (ESP) and the prospective budget review system.

The control group used in the analysis of prospective reimbursement in Rhode Island was composed of the 12 short-term general hospitals in Massachusetts for which casemix data were available from the Professional Activities Studies (PAS) for the time period under investigation (1969–72) [Thornberry, H. and Zimmerman, H., 1975]. The evaluators estimated the impact of prospective reimbursement through the estimation of a cost function with a dummy variable set equal to one for the Rhode Island hospitals in 1971 and 1972. The estimated coefficient for the variable is an estimate of the combined effect of the experiment and the Economic Stabilization Program in the equations using all observations from Rhode Island from the period 1969–72 and is an estimate for the separate effect of the experiment in using Rhode Island and Massachusetts control group hospitals for 1971 and 1972. The sign of the coefficient for prospective reimbursement was always negative, but only significant in the equations which estimated the combined effect of ESP and prospective reimbursement. For equations which measured only the impact of the experiment, the evaluators found the coefficient of the prospective reimbursement variable to be negative and insignificant. In terms of percentages, the impact of the prospective rate program on inpatient expenditures was estimated to be between 2 and 6 percent, depending upon the year and specification of the cost function.

NEW YORK

The State of New York and the State's Blue Cross plans operate the only prospective reimbursement system in the Nation which sets prospective rates solely on the basis of statistical formulas with no retroactive adjustment. Because of the magnitude of the program and the uniqueness of the experiment, there has been particular interest among health care researchers and policymakers in this program.

The New York prospective rate system began operation in 1970 and does not include a review of hospital budgets or analysis of their internal operations, but does, however, permit a hospital to file an appeal for the adjustment of its prospective rate after the prospective year. Hospitals complain often and vehemently that severe understaffing of the Division of Health Economics in the State Department of Health has rendered the appeals process hopelessly slow and completely unpredictable. There are between 150 and 250 hospital appeals submitted each year to the State Department of Health requesting an adjust-

ment of the prospective rate. Often, an appeal is pending for a year and in a few instances the final resolution of an appeal has taken over three years.

There are actually three different but similar rate setting programs in New York State which set reimbursement levels. The State Department of Health operates directly the program which establishes hospital rates in New York State for services received by Medicaid recipients, and it delegates to the local Blue Cross plans responsibility for setting Blue Cross payment rates. The Associated Hospital Service (AHS), the downstate Blue Cross plan, sets rates for Blue Cross patients in the 17 lower counties of New York State. The seven upstate Blue Cross plans jointly operate a prospective rate system which handles Blue Cross patients in the upstate region.

The State Department of Health, the Associated Hospital Service and the seven upstate Blue Cross plans' prospective rate systems are remarkably similar in content and process. The prospective rates in the New York systems are derived from actual costs incurred in the base year (two years prior to the prospective year). Routine costs of each hospital in the base year are subject to a ceiling which is equal to 110 percent of the routine costs for a group of similar hospitals. Any costs in excess of 110 percent of the peer group average are disallowed. The routine costs are then added to ancillary and education costs and a trend factor, which is derived from a three-year moving average of specified price indices, is applied to arrive at a prospective per diem rate.

Separate evaluations of the impact of the prospective rate program on Upstate and Downstate New York hospitals were conducted. The findings from the evaluation of the Upstate New York State hospital study are presented first.

The major findings of the Upstate New York State evaluation was that hospital costs grew less rapidly under prospective payment than would have been expected in its absence [Abt, Inc., 1976]. However, the estimates on which this finding is based are not statistically significant, suggesting both that there were considerable differences in the responses of the hospitals in Upstate New York State to the prospective reimbursement formula and that some caution must be exercised in generalizing these results. The estimated coefficients for prospective reimbursement in the cost analysis indicated that total costs per patient day were $.88 lower per year and total costs per case were $11 lower per year due to the prospective reimbursement program. This result, in turn, implies that prospective reimbursement has lowered the average cost per patient day by about 1 percent per year and the average cost per case by about 2 percent per year.

The cost containment impact of prospective reimbursement in Downstate New York State was examined by comparing cost increases in Downstate New York hospitals before and after the introduction of prospective reimbursement [University of Washington, 1976]. In addition, the level of cost increases in the Downstate New York hospitals was compared to the level of cost increases in the control group hospitals which were comprised of all hospitals in metropolitan Chicago, Cleveland and Philadelphia. The evaluators adjusted the cost figures for outpatient visits and the difference in input prices between regions and found a substantial downward impact on the cost per day and a moderate downward impact on the average cost per case attributable to the prospective rate program in Downstate New York State. After factoring out differences attributable to input price increases, the average cost per patient day rose 21 percent for Downstate New York hospitals as compared with a rise of 39 percent for the control hospitals during the 1968–74 period. And during this period, the average cost per case in Downstate New York increased 17 percent while the average cost per case in control hospitals rose 20 percent. These findings suggest that prospective reimbursement has lowered the average cost per patient day by about 3 percent per year and lowered the average cost per case by about .5 percent per year.

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Mr. VANIK. Mr. Smith's full statement describes, on page 8, the evaluations conducted by outside experts, which all point in the same direction; that is, prospective reimbursement systems seem to slow the increase in costs, but some systems are more effective in constraining the health costs than others and the impact is not always the same at each hospital.

Can you tell us why the difference? Have you any explanation for the variations?

Dr. GAUS. The systems are different themselves. Some deal with controlling the budget, some control only the per diem rates of payment, some are voluntary, and some are mandatory.

Of the seven that we have examined intensively, the two that seem to have the greatest impact are operating in a mandatory-type environment.

Mr. VANIK. You talk later on page 11 about programs in western Pennsylvania, South Carolina, and Rhode Island. Can you tell us when each of those programs began precisely?

I am leading again to the issue of the timelag between the mandate and the legislative reaction.

Dr. GAUS. Rather than take the time to recite the precise dates, in western Pennsylvania we signed a contract in the first part of January

1974, which would be about 2½ years ago, and we have been participating since then. The Rhode Island project, we have participated there since October 1974, and South Carolina was also around that time.

Mr. VANIK. Going back to the situation in Maryland, I am rather shocked that when the case hit the courts, it was apparently abandoned. Did you withdraw the support when the case was in the courts?

Dr. GAUS. We held our decision. I think that is the correct way to describe it.

Mr. VANIK. This was when someone who was working on a program needed help, needed support of the goals and objectives that brought them into the litigation?

Dr. GAUS. I think we still do look for significant and well-structured programs around the country to support, but our role is not to be advocating a particular form of reimbursement or being advocates for a particular project until we have participated in it long enough to know that it is a success.

The court decision in Maryland caught us before that time period; it caught us at a time when we were just considering participating in the project. So our decision was one to wait and see whether or not we, in fact, could and should participate in it.

Mr. VANIK. Dr. Gaus, on page 12 you say you have 14 proposals under consideration. They were all developed as a response to a special project invitation in September of last year. So apparently as far as these programs are concerned, it is going to be 4 years between the law and the startup for the programs. Do you have any comment on that observation?

Mr. SMITH. Mr. Chairman, I wonder if I could speak generally. I know the subcommittee is concerned.

Mr. VANIK. What we are trying to do here is to develop guidelines for future legislative decisions. Our feeling is that we have to know because Mr. Rostenkowski is working on a health bill, and he wants this information developed through our oversight subcommittee so that he knows what course of action to take in the future bill.

Mr. SMITH. I think that is quite understandable. I think this subcommittee, other subcommittees, and we ourselves are not totally happy with the pace of development in this area of medicare program experimentation. But to go back to some of the things I said earlier, this area of constraining health care costs is a terribly difficult area.

Second, there was work going on in the country at the time when the Senate Finance Committee inserted this provision in the bill and Congress enacted it, and there were varying experiences under those efforts which were going on. So the question, I think, is should the Social Security Administration have plunged in at that point? Did it know enough to plunge in? Did it know what it wanted? Did it have any idea of what conceivably would have been useful, or did it need some time to examine what was going on in the country?

I think that what was done through those 11 descriptive case studies was an examination of the state of the art; and second, I think some of the early experiments, the one in Connecticut I will refer to again, and some of the other early experiments, suggested that we really needed to define better and establish more rigorous conditions for our participation than was possibly first thought to be necessary.

I think we had to fall back and do that. After an attempt to receive unsolicited proposals, we really had to step forward and say, no; we have to define better some of the terms and conditions of our participation in these projects, and that, unfortunately, takes time.

Social Security, I think, generally enjoys a pretty good reputation in its research and demonstration fields in the country at large, and I think it enjoys that reputation because it is fairly meticulous and careful about the way it designs projects, the way it enters into them, and the degree to which it evaluates those.

I think we have concluded that that process takes more time than initially was anticipated. I think today unfortunately the position we are in is that there are so many ways to do prospective reimbursement, and the experiments have not shown up to the present time a significant reduction in costs; so here we are dealing with evaluations of a relatively small number of experiments, and we do have to be a little cautious. The experiments have not shown a sufficient reduction in costs that we would suggest to you that it is time we plunge forward with a mandated system.

We really believe that it is more appropriate to continue in an experimental demonstration mode for several more years.

Mr. VANIK. This final question passes through my mind. Why did it take so long to get a contract on current costs?

Dr. GAUS. I think particularly we were concerned about the proposals that we are now working on. What I can share with the committee is that, first, this type of proposal, I think, spells out and has in it a lot of information that wasn't known years ago.

Second, the proposals have been analyzed by our technical staff as well as a lot of experts on the outside. The sobering part about all of this is even now, 4 years after the legislation and after a lot of States have put a lot of work into this, it is not clear to us that the proposals we have received, in fact, will result in effective, efficient prospective reimbursement systems. Some of them will, we believe, and we are going to fund those.

But the state of the art in the field, not within SSA but in the States, is still limited, and I think the people we have around the table here from Maryland and Connecticut and Rhode Island and Michigan are very expert in this area. But there aren't a lot of others around. There certainly are not 50 others for all 50 States.

We believe that this expertise has to be developed over a period of time.

Mr. VANIK. Mr. Rangel.

Mr. RANGEL. I have no questions, Mr. Chairman.

Mr. VANIK. Mr. Stark.

Mr. STARK. I would just come back and see if in your studies you have done anything like trying to categorize, I guess, what I refer to as the "I hurt" kind of medical care as opposed to the high-cost, space-oriented medical care.

The high-cost care, have you broken that out in your studies at all?

Dr. GAUS. I can't recite you precise figures. We have done studies as to the types of factors leading to cost increases and whether they are the simple kinds of procedures or the complex and sophisticated. Our estimates are that at least half of the cost increases each year in hos-

pital care are attributable to high-cost technology and sophisticated, new procedures.

Mr. STARK. Would you then relate that to how many citizens actually participate in that?

Dr. GAUS. Again, these are a minor part of the hospital population.

Mr. STARK. Would you say something like 50 percent of the cost increases are going to take care of 2 or 3 percent of the people? Is it that dramatic?

Dr. GAUS. It is probably in that range.

Mr. STARK. There is one other area that concerns me. Have you any cost comparisons of the cost advantage of new hospital units in terms of the capital investment for a new room as opposed to the potential laborsaving over an old room? In other words, it seems to me that if you tear down or abandon a hospital that is 20 or 30 years old, it is impossible to obtain more than $1,000 a room, whereas to build a room costs much more.

It seems to me that there ought to be some cost comparison. Admittedly the older hospitals take more labor to operate, but has anybody done any studies in that sense? Are you really at the point where the laborsavings from new facilities are very marginal if you take into account the cost of capital to replace an old facility? Has anything been done in that line?

Dr. GAUS. Let me comment. I think the other people may want to, too.

Our studies would indicate that the new hospitals, newly developed and newly built, probably are more expensive than those that are not. What happens in the reconstruction of a hospital or the rebuilding of a hospital is the hospital itself changes—that is, the nature of the service or the equipment they buy—and it is not clear that the tradeoffs on laborsavings through more efficiently organized facilities are, in fact, outweighed with the added new equipment and intensive type of services that generally go into a hospital.

Mr. STARK. In other words, people just don't like to buy the standard transmission, no air-conditioning, plain cloth upholstery models. You want to have what everybody else on the block has and have all the gadgets and whistles and bells. Is that a fair interpretation of what you say?

Dr. GAUS. It is notoriously a first-class industry.

Mr. GRIFFITH. That is a reasonable statement. In Michigan one of the costs for reconstruction of hospitals has to do with the improvement of licensing laws, so that facilities that were adequate once are not now adequate.

Mr. STARK. Does that pressure come from the people like the Johnson Service Co., or do you find them coming from the professionals? It seems to me the nicest way to sell a new gadget is to get it written into the licensing law or into the specifications.

Mr. GRIFFITH. It comes from the professionals, not the vendors, so far as I can tell, but the professionals seem to be quite unconcerned about the cost implications of what they are doing or the fact that the hazard that they have just pointed out may have existed for 50 years and nobody has yet been apparently harmed by it.

Mr. STARK. Thank you very much.

Mr. VANIK. Thank you very much.

I have several questions. First, I suggest that if any of the panel members have any questions, they may address them to each other or to the Government witnesses.

Mr. FORAND. I would like to comment on this capital issue. It is an important one.

Mr. VANIK. We are dealing with this all the time, either people pay more or we give away some of the tax resources of the country. I receive letters by the hundreds from important constituents in business who say we have to do something about the capital shortage situation, and I write back to them and say I know you want a cut in your taxes, but isn't there another way? Can't you create capital either by becoming more efficient or by developing some internal means to do it?

It seems it is always either the consumer or the Treasury that has to bear the burdens of capital formation. I am not among those who want to dismember the Government.

One letter will tell me to create capital, to cut the taxes and another letter will tell me to cut out all the functions of government. Some people want to build an anarchy State in which the Federal Government will be operating like a Lilliputian. Frankly, I am a believer in government and I think that it functions better than we get credit for and than is most generally acknowledged. Concerning this general subject, I am not among those who want to destroy the bureaucracy of this country, which does render very important, vital services to the system. I think there are some fat and excesses throughout the system, but generally it works extremely well.

As a matter of fact, for some time it worked without any executive guidance and carried the country through some very difficult periods.

Now, with that aside, I would certainly be happy to hear from you.

Mr. FORAND. I would like to echo the comments made by Drs. Gaus and Griffith. Invariably when a hospital requests permission to replace an antiquated facility, there are claims made that it will result in a more efficient use of personnel, but in the end it always results in increased costs. It seems that boards of trustees and administrators tend to build monuments to themselves which end up costing the consumer a significant amount of money.

Mr. GRIFFITH. I encountered that monument problem many times, but please understand that throughout the 1960's and early 1970's the Congress not only said we will pay for whatever you spend, Mr. Trustee, but in addition, through our Hill-Burton program we will help you spend it.

Mr. VANIK. Mr. Pickle.

Mr. PICKLE. May I reserve my questions? I have some questions.

Mr. VANIK. Mr. Gibbons.

Mr. GIBBONS. As I understand it, the thrust of your recommendation here today is that you have not put prospective reimbursement into the system yet. You want more time to experiment with it.

Mr. SMITH. The findings show some cost constraints in those we have experimented with. There are, in fact, a variety of methods of prospective reimbursement systems which could be applied and although we are closing in on what we think are the more effective of those various systems, I don't think we are yet in a position to recommend to you a system per se.

Mr. GIBBONS. When do you think you will be through researching it?

Mr. SMITH. I asked Dr. Gaus that question earlier. One of the things we will be participating in, and we are just beginning and we hope to enter into the contracts between now and September, are a number of experiments dealing with State ratesetting efforts where there is combined the ratesetting activity and the planning activity or a close integration between the two. In addition, they generally provide for participation of all the major financiers.

I would say in the normal course of events it would be another 2 or 3 years before we would have the findings of those experiments.

Mr. GIBBONS. I realize—my question was poorly phrased—that there is really no end to any true research and there is no final solution to any of the problems we have, but you say that within 2 or 3 years you think you could recommend to us whether we should change the current system and how to change it; is that right?

Dr. GAUS. I think we hope to know enough at that time to make recommendations.

Mr. GIBBONS. Thank you. Those are all the questions I have.

Mr. VANIK. Mr. Pickle.

Mr. PICKLE. First, I want to ask you gentlemen if you have any jurisdiction over the reimbursement rates or prospective payments with respect to nursing homes. Or are you talking about the tax-exempt organizations?

Dr. GAUS. Our authorities do cover nursing homes.

Mr. PICKLE. Including the privately owned?

Dr. GAUS. Yes. Most of them are. The medicare program, of course, does not have the bulk of that long-term care industry, but the departmental authority does cover both.

Mr. PICKLE. Apparently the law says now that you would be reimbursed on the base of reasonable contrasting methods, and in general I think my State is satisfied about the way this is being carried out, primarily because they are leaving most of this to the State. Is that the intent of HEW, to leave the interpretations primarily up to the States, and would you accep the State's method of reimbursement?

Dr. GAUS. With respect to the medicaid program, that is largely the case, given some certain boundaries and regulations. With respect to medicare, there is a national cost reimbursement standard.

Mr. Blumenthal may want to comment further.

Mr. SMITH. About 80 percent of the nursing home beds in the country are being financed through the medicaid program. That program is administered by another part of HEW, the Social and Rehabilitation Service.

Mr. PICKLE. So you would not be concerned about that primarily?

Mr. SMITH. Not primarily. We are reimbursing some nursing homes obviously, but the main financer is the medicaid program.

Mr. PICKLE. It is a very difficult and knotty problem, and as much as possible I would recommend that you try to leave to the States as much jurisdiction on that as you can. If you can keep them happy working with your State representatives and coordinating with your operation, that is better for us all the way around.

In my State, I don't know whether there was a suit brought or not, but it is a very ticklish problem.

Mr. BLUMENTHAL. Mr. Pickle, the medicare program is a Federal program administered federally under a statutory formulation of reimbursement which applies uniformly. We don't look to the States

under the statutory directive we have for the determination of reimbursement to nursing homes or to hospitals except to the extent that we have indicated this morning under the experimental project in which we participate.

Mr. PICKLE. Do you have any experimental projects?

Mr. BLUMENTHAL. On nursing homes, not at this point.

Mr. PICKLE. Do you contemplate them?

Dr. GAUS. Yes, we do.

Mr. PICKLE. In our State?

Dr. GAUS. I am not sure whether the proposal from Texas does. There are two things I should mention here. One is prospective reimbursements in the nursing homes and skilled nursing facilities. We are really just beginning to undertake experimentation with the States there. We have had several propects which do deal heavily with nursing homes, both in medicare and medicaid points of view, with what we call the "swing bed concept" which in Texas, western Iowa, and South Dakota, we are now preparing to participate on a reimbursement basis, as we are doing in the State of Utah.

So, yes, your nursing homes in the State of Texas will be part of that, are part of that, project, in fact.

Mr. BLUMENTHAL. In that regard, even in the swing bed projects this would not be under the direction of the State, nor would it be under reimbursement principles established by the States.

Dr. GAUS. The medicare program cooperates with the State in the sense that we have the same methodology, the same way of reimbursing in those States for medicare as the medicaid program, but again that is on an experimental basis only, and only in Texas, Iowa and Utah.

Dr. COHEN. Mr. Pickle, the Maryland commission has authority to do rate review of all nursing homes in the State. That authority began July 1, 1975. We are not exercising that authority, because 70 percent of the nursing home beds in Maryland are medicaid patients, and 3 percent are medicare, which is very small, and neither of those parties has indicated that they are ready to pay commission-approved rates.

We believe under the circumstances we would be wasting State taxpayers' money if we tried to review all the budgets of the 200 nursing homes in the State and we were approving rates that would have no effect on the vast bulk of the patients.

So I think it is quite important that medicaid—I think in nursing homes it is primarily medicaid—make some decisions.

Mr. PICKLE. I can understand why you wouldn't want to have that extensive a jurisdiction. I am just asking in either medicare or medicaid that you ask for the cooperation of the States. Quite often, though, it may be a Federal program, you basically coordinate with your State operators and if you don't have that cooperation, it makes conducting a good program more than twice as difficult.

Dr. COHEN. I have a staff in the State program in Maryland and the reason we don't set the rates there is for those I mentioned.

Mr. PICKLE. Mr. Chairman, I have another minute or two? I want to ask you a question now with respect to hospital costs and health care costs and increases. It may be something you have already talked about.

The President proposed that he was going to restrict annual increases on bills reimbursed under medicare to 7 percent for hospitals and 4 percent for physicians. My people object very much because they say these costs have gone up as high as 14 percent.

My question is, has the level of increases been determined? Are you still considering that? Has that been acted upon or is it still a matter that is in flux? Has either the Congress or the administration taken any form of action about the limitation of this?

Mr. SMITH. That has been included in the President's program for this year, the 7-percent cap and the 4-percent cap.

Congress has not acted on those proopsals yet. Of course, you are quite right, and the people advising you are quite right, the costs are going up faster than that. That is the problem.

The problem is that the spiraling increase in health care costs is such that we are searching for methods to control them. The 7 percent and 4 percent were proposed as interim stopgap measures for a period of 2 years while we really try to assess what are some more appropriate and better ways over the long term to control those costs.

Dr. COHEN. Malpractice and utilities alone are causing hospital costs in Maryland to go up between 2 and 3 percent just to put the 7 percent in perspective.

Mr. PICKLE. Salaries and utilities——

Mr. VANIK. You have all that free gas down there.

Mr. PICKLE. We are giving that free gas to Ohio and California.

Let me ask you about the question of out-of-pocket payments under medicare. The President has proposed a limitation of, I think, $500. Apparently he would require the patients to pay the first $104 and then 10 percent of the cost successively on each day. Has that been acted upon? Has there been a decision made on that?

Mr. SMITH. Again that is a part of the President's program which would revise the current cost-sharing structure and put a cap on beneficiary liability so the expenses above certain dollar limits would be paid entirely by the medicaid program. But that again has not been acted upon by Congress.

Mr. PICKLE. Have the regulations on the out-of-pocket expenses and costs in general—have they been issued by HEW?

Mr. SMITH. You mean constraining the amounts of payments by the individual patients?

Mr. PICKLE. Not so much the $500, but I just think about regulations as a whole. One of the problems I have got is the classifications. My city of Austin is still a "small town" classification. I want to know is that still as it was? Do you understand?

Mr. BLUMENTHAL. Yes; I do. I think you have reference to the cost limits for hospitals under the classification system that was required under the 1972 amendments.

Yes; we just issued by regulation a revision in the cost factors, so that they now reflect more currently——

Mr. PICKLE. When did you issue those?

Mr. BLUMENTHAL. Within the last 2 months and this is for the next ensuing fiscal year, so this would be a prospective recognition to take into account the cost reporting periods.

Mr. PICKLE. I had not seen those regulations. Would you get me a copy of them?

Mr. BLUMENTHAL. I will be happy to.

Mr. PICKLE. I guess pending receipt of that I will be back in touch with you on that. That is all the questions I have right now, Mr. Chairman.

Mr. VANIK. Thank you very much.

I want to thank you gentlemen for participating in this hearing today. I want to thank you, Dr. Griffith, Dr. Cohen, Mr. Forand, Dr. Gaus, and Mr. Smith. We very much appreciate your cooperation. It is only in this way that we are going to arrive, I think, at a viable program in which we might endeavor to contain and watch the cost factors in this program.

I hope we can get something worked out in time to be useful to the legislative committee. So I would hope you could give us a model program, that we might place in the record. Give us at least the things that you think would be the elements in a model program so the Health Committee can move forward on this matter.

Mr. VANIK. I want to announce that Monday at 2:30 in this room our colleague, Mr. Vander Veen, will chair his committee's hearings on more research and development. It doesn't have anything to do with what you were talking about today.

On Friday, 10 to 12, we are going to have a PSR hearing with HEW and at 1 o'clock next Friday we are going to have a hearing on taxpayers' services at which the Commissioner will be present.

I want to thank you very much for your cooperation. This committee is now adjourned.

[Whereupon, at 12 o'clock noon the subcommittee recessed, to reconvene at 2:30 p.m., Monday, May 17, 1976.]

[The following was submitted for the record:]

SLIPPERY ROCK STATE COLLEGE,
DEPARTMENT OF ECONOMICS AND BUSINESS,
Slippery Rock, Pa., June 11, 1976.

HON. CHARLES A. VANIK,
Chairman, Oversight Subcommittee,
Committee on Ways and Means,
House of Representatives,
Washington, D.C.

DEAR SIR: I have recently learned of your interests and the concerns of your committee as regards the management and control of reimbursements to hospitals under federal programs. I have also learned of the bill submitted in the Senate by Senator Talmadge, "Medicare-Medicaid Administration and Reimbursement Act." The bill (S. 3205), as I understand it, seeks to create a Health Care Finance Administration and to specify uniform principles for administering and controlling reimbursement to hospitals. Since your committee is interested in this problem, and since the House may be concerned with the development of a companion proposal, you may be interested in some of the ideas that I and my colleague, Dr. Jesse Hixson, have recommended regarding the specific problem of controlling reimbursements to hospitals for services provided under federal programs.

Our own views are described in the enclosed paper, which was written with the deliberate intent of offering a theoretical and operational basis for a research agenda. Specifically, the paper proposes an alternative to cost-based hospital cost-inflation problem. The alternative we propose is an administered price system in which rates are set by a central authority on a periodic basis. The paper describes the basis of such a system, how it can overcome the problems associated with cost-based reimbursement, and how such a system can be designed and implemented.

Although the legislative background to which we were responding (described in the paper) may become mute in view of new congressional initiatives, we believe the alternative we propose is general in its relevancy. We accordingly place our ideas respectfully in your hands. It is hoped that the alternative described will be useful to you.

Sincerely,

PAUL N. WORTHINGTON,
Associate Professor.

Enclosure.

An Administered Price System for Hospitals[1]

(By Jesse S. Hixson and Paul N. Worthington, Slippery Rock State College, October, 1975)

I. INTRODUCTION

The purpose of this paper is to suggest a better system of setting reimbursement rates for hospitals. The system we propose overcomes many of the deficiencies of the present cost-based method of reimbursing hospitals and satisfies general conditions for efficient resource allocation. The proposed system includes a systematic program for estimating the costs necessary in providing inpatient care to various categories of patients within a framework which classifies hospitals into comparable groups for the purpose of comparing their operating efficiency. This program is offered in this paper as an agenda for research in which the assumptions upon which our proposed system are based can be tested.

The system we propose is an administered price system. We propose an administered price system because, in looking forward to the prospect of national health insurance as well as at the historical development of third-party reimbursement, we see an administered price system as the only system compatible with the increasing concentration on the buyer's side of the market and which can achieve some measure of economic efficiency for the hospital industry. Although prices in our system are determined by a central authority, the principles underlying their determination are market principles, and the system is designed to achieve the efficiency of competitive markets.

In the following section, we review the circumstances motivating this proposal and discuss the principles which should be followed in designing an effective price system. In Section III, we discuss our proposed approach to grouping institutions for the purpose of rate setting and empirical techniques to be used in determining the classifications of hospitals. In Section IV, we discuss the steps to be taken in determining the initial prices to be set for each group of hospitals. With data presently available, the conduct of the empirical research discussed in Sections III and IV can be viewed only as a demonstration of the system we propose. Therefore, in Section V, we discuss further research that must be undertaken to refine the system into one that can be implemented. This includes the development of uniform definitions of facilities, services, and case-types for the system. In Section VI we discuss the principles which guide the administration of the price system. The discussion will also include suggestions for developing uniform information systems to be used in administering and revising prices through time.

II. BACKGROUND

Our administered price system is proposed in response to the demand for such a system voiced by the Congress in several recent pieces of legislation. These are, first, Sections 222 and 223 of P.L. 92–603, the 1972 amendments to the Social Security Act, and second, Section 1533(d) of P.L. 93–641, the National Health Planning and Resources Development Act of 1974. Section 222 mandates experimentation with different types of prospective reimbursement, while Section 223 calls for the setting of limits on Medicare reimbursement based on estimates of the necessary cost of efficient delivery of services. More pointedly, Section 1533(d) calls for the design of a system to calculate rates of reimbursement as well as systems of cost accounting and reporting to be applied in health service institutions. This and other legislation, as well as a growing body of literature, document the fact that an administered price system is seen to be the only viable substitute for the traditional cost-based method of reimbursement by those who must grapple with the waste and inefficiency within the present system as well as by those who must contend with the prospect of national health insurance. In spite of this recognition of the necessity of administered prices within the context of third-party payment systems, little recognition of the basic principles of design for such a system has been apparent in the various attempts to implement novel reimbursement or regulatory systems in response to Congressional or other mandates. It is only in view of the basic principles and objectives which an administered price system is meant to achieve that the relative merits of proposed systems can be fruitfully discussed. This section, therefore, is devoted to a discus-

[1] Edited by Oversight Subcommittee staff.

sion of those principles and objectives which provide the background for our proposed system.

A. The defects of cost-based rate setting

The major factor underlying past cost behavior and performance of the hospital industry is the traditional cost-based method of determining rates of payment or reimbursement to hospitals. This system of payment as it is currently utilized has several distinct characteristics which have undesirable consequences for economic efficiency.

First, rates of payment are functions of historically incurred costs. Thus, under cost-based pricing as currently employed in the hospital industry, reimbursement is essentially a reward for incurring costs. The system is administered by a variety of "third party payers" who agree to reimburse hospitals for the "reasonable cost" of "necessary" services provided to their beneficiaries. The terms "reasonable cost" and "necessary" are seldom provided with definitions. In such an atmosphere, incurred costs are ipso-facto reasonable and necessary and are passed with little resistance through the partnership relation that has evolved between hospitals and third party payers. With such a relationship, little immediate pressure is felt by providers from the buyer's side of the market to constrain the incurment of cost on their behalf. This method of reimbursement, rather than encouraging efficient production, encourages cost incurment through various means leading to extravagance, proliferation and inefficient employment of redundant facilities, and over-consumption of services and excessive length of hospital stay by many patients.

General dissatisfaction with this situation has stimulated experimentation with alternative schemes of so called "prospective reimbursement" in which attempts are made to set rates of payment to prevail for a given time in the future as opposed to reimbursing hospitals at rates of cost incurred in the past as is done under the traditional "retrospective" rate setting system. While the basic idea of prospective reimbursement—that prices to be paid for services must be established before production starts rather than after production has taken place if inefficient and unnecessary delivery of inpatient services is to be reduced—has much intuitive appeal and is widely acclaimed, the idea has yet to be transformed into a comprehensive and systematic approach to the setting of rates of payment. Most of the currently practiced methods of prospective rate setting retain too much of the flavor of cost-based reimbursement to be effective, while the basic principles for constructing an effective prospective rate system have yet to be spelled out.

Under the system of reimbursement of undefined reasonable cost to providers of services, the relationship of cost to reasonableness is further obscured by a second major defect: the industry practice of average cost pricing. The major problem inherent in average cost pricing which has led to inefficient employment of resources in the hospital industry lies in the fact that under average cost pricing, a vital link between revenue and utilization is severed—vital because its severance eliminates the pressure to strive for efficiency. Under this system, additions to incurred cost need not be accompanied with an expansion of revenue that results from an increase in the provision of services. The rate of patient care can in fact remain unchanged, and average cost pricing will generate new revenue by increasing reimbursement rates. This eliminates any necessity on the part of hospitals to assess the relationship between added costs and added patient care to determine whether new revenue will cover and new cost; and it makes duplication, under-utilization of services, and idle facilities commonplace in the industry.

Not only is price subject to manipulation by the producer under average cost pricing, but the composition of output can be manipulated for financial advantage as well. For, once a price has been determined on the basis of a given historical expense, the hospital is presented the opportunity to increase its surplus from reimbursement by increasing the rate of flow of those services whose marginal resource costs are less than the average rate of reimbursement or by decreasing the flow of services whose resource costs are greater than the average rate of reimbursement. The surplus acquired in the course of such changes in output can then be used to subsidize the provision of other services whose costs exceed the average rate of reimbursement, while the average rate of expense remains at the same level. Such opportunities afforded hospitals by the system of averaging cost pricing have no doubt contributed to the proliferation of facilities and services which has resulted in excess capacity of many sophisticated facilities accom-

panied by over-hospitalization and over use of facilities in other dimensions of acute inpatient care.

A third major defect of the current system of hospital reimbursement lies in the fact that rates are typically computed for each hospital individually. By treating each hospital individually, it is argued, the system recognizes the individual differences between hospitals that disappear when hospitals are viewed from some higher levels of abstraction. However, the justification for a unique rate is based on a purely circular view of the behavior of average cost. It is argued that, for example, because costs are averaged over broad categories of patients, average cost is higher in one hospital than another if its patients are composed of more costly type cases. This argument could not arise if reimbursement rates were not based on average cost. Although it recognizes individual idiosyncracies of hospitals, such a system is void of the competitive pressures for achieving efficiency which would operate if hospitals in essentially similar circumstances were treated equally in the eyes of the payment system. In the absence of such pressure, hospitals in similar circumstances are not compared to each other in terms of operating efficiency, with the result that relative inefficiency or extravagance neither stands out nor is penalized. There is no penalty for inefficient production and no reward for efficient production under such a system; only the incentive to incur cost is present when a hospital's performance is not compared to that of other institutions operating in similar economic environments. The results of such a situation is that the services provided to identical patients by hospitals operating in identical economic environments can differ widely in scope intensity, and composition while still satisfying the criteria of "reasonableness."

A fourth major fault in the current system of hospital reimbursement is the unit of payment. It is now widely recognized that reimbursement on the basis of cost per day provides opportunity and incentive for hospitals to extend length of stay in order to increase revenues. Likewise, reimbursement for each of the individual services provided to the patient provides opportunity and incentive for hospitals to increase the use of such services per patient day and per episode without the necessity of justifying such increases in terms of productivity or efficiency.

What properties should a price system have to overcome the deficiencies of the cost-based reimbursement system discussed above? Clearly, reimbursement should be a reward for producing a service and not a reward for wasteful or harmful use of resources as it is under the present system. This means that the price system to be employed should minimize incentives to provide superfluous or unneeded services to beneficiaries and should maximize incentive to provide needed services at minimum cost. Unless buyers pursue maximum value for their expenditures, little pressure for efficient production is felt by providers. As the buyer of services for its beneficiaries, the third party payer has the responsibility to exert this pressure on the market to assure that no more is paid than is required for the services that its beneficiaries consume. The third party payer has the responsibility to reimburse no more than the lowest cost at which services can be generally made available to its beneficiaries in a given economic environmental context. To allow the reimbursement at higher rates is simply to invite all costs to rise unnecessarily to those rates, as well as to exempt beneficiaries from exercising prudence in their demands on the health care system.

Reimbursing only the lowest cost at which given services can be generally made available in a market will serve to integrate the necessary element of competition into the pricing system. The idea of paying each hospital in a given market context the same price for a particular type of service, based on the lowest cost for which such a service can be generally provided is neither offensive to common sense nor inconsistent with practices in the private sector or with principles of government procurement. To incorporate this idea as a principle of hospital payment, however, the unit of service must be defined in such a way that permits an individual supplier no means of determining or influencing the rate of payment he receives. In other words, reimbursement rates must be defined in such a way that minimizes the amount of discretion which a provider has to manipulate the terms by which he obtains revenues. In the hospital context, the only unit of reimbursement satisfying this condition is the episode of hospitalization rather than its components such as the patient-day or the individual routine and ancillary services. Only by defining the unit of reimbursement as the hospital episode or the case can these incentives for unnecessary overuse of resources be removed from the remibursement scheme.

It is not sufficient, however, to simply shift from the present practice of per-diem pricing to one of per-case pricing. The rate of reimbursement must reflect the resource cost of producing each type of case, rather than the average expense of treating all of a hospital's cases, as it would if the present practice of average cost pricing were carried over into the new payment scheme. Only if prices reflect the incremental or marginal cost of each case type can revenue be established as a function of output and inducement to expand unneeded services be eliminated. The basic objective of a price system designed to promote efficiency in the hospital industry is to remove control over the rates of payment from the hands of the hospital, and to eliminate incentives for wasteful or inefficient operation. To eliminate such incentives, prices or rates of payment must be defined on a per-case basis, and the prices so defined must reflect the incremental costs of treating each type of case. To assure that these costs are minimum necessary costs, incorporation of the lowest generally available cost procurement principle into the payment scheme will serve to introduce the necessary element of competition and consumer prudence.

Hospitals, to a considerable extent, are insulated from the market pressure of consumer sovereignty. The power of expressing effective demands is concentrated in the hands of third parties, via hospital insurance or publicly financed programs. If prices are to serve a constructive function in such circumstances, the mechanisms determining them must attempt to duplicate the workings of a market mechanism—because only the results of a working market mechanism (under stipulated conditions) are known to satisfy conditions for the efficient use of resources. In this situation the first responsibility of the third party is to its clients or membership—not the hospital. The funds it spends are the resources of its clients, and when it spends more than necessary in behalf of particular clients or members it simply deprives all of its clients or membership of benefits or services. Hence, it is the responsibility of the third party payer to implement and adhere to the principles of price determination which will allow prices to perform those functions which benefit consumers and society in a market system. In other words, it is the responsibility of the third party payer to administer prices in a way that duplicates the results of a market system. In the remainder of this section, we discuss the principles which must govern the conduct of an administered price system if it is to achieve these results.

B. Requirements for an administered price system

The major objective of an administered price system in the hospital industry will be to encourage economic efficiency in the organization and delivery of health services. In accomplishing this objective, the administered price system will gradually force the elimination of excess capacity, redundant facilities and over-consumption of services which has arisen under cost-based reimbursement, while leading health service institutions to minimize costs of production and operation. This is accomplished by setting prices to which decision-makers in health service institutions respond as they determine their supply responses to the demands implied by those prices. An administered price system replaces the market mechanism of price determination with an administrator who determines prices according to certain rules. Although the automatic mechanism of the market is replaced by a central price setting authority under an administered price system, the administrator must utilize the same market signals and information generated by the behavior of the market to guide his decisions through successive rounds of pricesetting to converge to the "right" prices. The administrator works by observing the response of consumers and producers to a given set of prices, and adjusting the prices to improve the solution. If prices are not "right," certain market signals will indicate to the rate administrator that they are either too high or too low and must be adjusted accordingly. There are many of these market signals that must be monitored and diagnosed according to a definite symptomatology by the rate administrator in the course of performing his function in an administered price system.

In order to be effective and efficacious in achieving the objective of efficient organization and production of health services, the price system depends on hospitals adjusting their production and supply to a given set of prices, the prices must be beyond the control of individual health service institutions. In other words, the prices must be regarded as parameters of their economic environments by hospital decision-makers. This condition has the effect of making it impossible for the hospital to separate revenue opportunities from considerations of productivity. With prices given and beyond hospital control the only way

additional revenues can be obtained is by increasing the provision of some service(s)—either by improvements in the allocation or technical efficiency of resources, or by employing additional resources. By necessity under parametric prices, any action contemplated by decision-makers which gives rise to an expenditure of funds must be assessed in terms of the opportunities available for obtaining sufficient revenue to provide those funds; and since revenue comes only from provision of services, it will be necessary to evaluate any such activity in terms of its implications for productivity. This condition imposed on decision-making is in sharp contrast to alternative pricing arrangements such as conventional cost-based reimbursement schemes where the hospital is allowed to influence the terms by which its revenues are obtainable. Under cost-based reimbursement, for example, there is no need to be constrained by productivity implications since additional revenues can be obtained by using the expense of activities to increase the reimbursement rate.

A second property, corollary to the requirement that prices be independent of the behavior of an institution, is that the terms for obtaining revenue must be based on an appropriate unit of output. To be consistent, output, for this purpose, must be defined as the broadest possible aggregate of components which can be identified generally as a unit for satisfying demands under the program. The case, i.e., the hospital episode, is the appropriate unit of output for this purpose. To see this, one need only note that to fix prices on the individual components of service (such as room charges, diagnostic and therapeutic procedures, use of operating rooms, drugs, or a "patient-day") makes it necessary for the hospital to consider revenue alternatives in terms of the provision only of these components; in this case, decisions to finance additional activities must inevitably be viewed in terms of the financial possibilities made available by increasing the provision of these components of service independently of the number of cases treated. If based on individual components of service, an administered price system may possibly result in the efficient (least costly) provision of components of services; however, since no "budget constraint" or price is attached to the case or total expenditure per hospital episode there is no compulsion for hospitals to consider opportunities for substituting components of services in treating individual cases. Hence, there is no reason for expecting costs to be minimal for the case. In other words, total cost incurred for a case, even though such costs might be efficient in terms of the components of services, would be more than necessary to treat the cases involved. The reason for this is that hospitals can expand, with few restraints, the provision of service components to increase the revenues they can obtain from the individual case. Moreover, fixing of a single set of prices on service components for a group of hospitals is inconsistent with the solution for optimal combination of services if the hospitals have different case mixes, due to the fact that the opportunity for substituting service components will differ across hospitals with different case mixes. Fixing prices for hospitals on the basis of service components may place an upper limit on costs, but it will not in general result in minimal costs for the cases treated and hence minimum program cost.

A second aspect of this property, not to be neglected, is that types of cases which differ with respect to the behavior of marginal costs must be assigned correspondingly different prices. This is necessary in order to enforce a strict functional relationship between revenue and output which will not obscure the implied productivity test in reaching cost decisions. In particular, with parametric prices corresponding to incremental case costs, new revenues to finance contemplated cost increases can *only* come from increased production of cases. This property of prices compels *all* cost alternatives to be judged from the point of view of productivity.

The third necessary property of the administered price system is that the prices imposed on health service institutions must be the same for all institutions facing essentially similar economic conditions. For, it is the conditions of the hospitals' economic environments which ultimately determine the bounds on their behavior and the limits on the extent to which they can achieve efficient operations, and all hospitals facing homogenous sets of economic factor market and demand market conditions are capable of achieving the same degree of efficiency in their operations. By imposing a uniform set of prices for all hospitals operating in the same economic environment, the rate administrator forces hospitals to adjust their behavior to the prices they face while leaving them free to pursue their own interests within the constraints of the price system. Economic necessity will, however, compel them to converge toward a uni-

form and efficient organization and production of health services if they are unable to manipulate their operations to qualify for another set of prices. Thus, the prices must be insulated from the control of the institutions as pointed out above, and price differentials faced by different hospitals must be based solely on factors differentiating their economic market environments which define the constraints on hospital behavior.

The preceding paragraphs have discussed the properties that prices for hospital services must have if they are to perform a useful function in the hospital industry. If prices do not possess the three basic properties outlined above, they will only serve to encourage inefficiency, waste, and over-production of capacity and service in the hospital industry in the same way that cost-based reimbursement does at the present time. Although the recognition of the perverse consequences of cost-based reimbursement has led some to embrace the concept of prospective reimbursement as a route to controlling the cost of hospital care, others have promoted variants of an alternative approach which consists basically of imposing administrative regulations and controls on the operations of hospitals while preserving cost-based reimbursement. This alternative approach is manifested currently in such devices as utilization review, certificate of need, professional standards review organizations, and local health planning agencies. Before turning to discussions of the empirical research necessary to design and implement our proposed price system, we wish to discuss and compare the implications of these two alternative approaches to control of costs of hospital care.

A general point that cannot be over-emphasized is that any regulatory system that is super-imposed on a cost-based or retrospectively determined price system must work against the perverse incentive effects of inappropriate prices. Such a system is destined to be in perpetual disequilibrium and enforcement of supplementary rules and regulations will resemble a never-ending game of cops-and-robbers. The choice of such a system entails a commitment of resources year after year to a use which can achieve no permanent effect or lasting value. In contrast, an appropriately administered system of prices which have the three properties discussed above will require no auxiliary police force to supervise the activities of hospitals, doctors, and their patients. For, it is the response of these parties to differences in prices and changes in prices that makes the system work and which generates the information with the central price authority requires to move the system closer to an equilibrium state. In the administered price system, prices serve a useful, meaningful, and constructive purpose in contrast to the purpose they serve in the alternative system where their perverse effects must be counteracted by cumbersome administrative and bureaucratic burdens on the operation of the health care system.

A second important point is that while the criteria by which prices are determined in the properly administered price system are objective and impersonal criteria, the criteria by which administrative regulations in alternative systems are interpreted and imposed are almost universally subjective and are applied inconsistently and arbitrarily. For example, certificate of need, local health planning, and similar schemes require case-by-case application by committees, boards or panels of ill-defined or undefined notions of "need" to arrive at decisions. Until an objective notion of "need" is discovered and a universally applicable method of measuring it is invented, decisions made under these alternative types of systems must necessarily be irrational, inconsistent, and arbitrary. Moreover, any such system whose administration requires the day-to-day and case-by-case application of human judgment naturally fosters antagonism between parties with competing interest, leads to ill-will and inevitable charges of favoritism and bias against the administrators, prolonged legal confrontations, and is susceptible to inappropriate outside influence and pressure. A similar problem is associated with schemes which use peer review or professional standards as criteria for regulation. Professional standards, particularly in medicine, have little scientific or objective validity; rather, they are established by fashionable practice, are always subject to exception, and determination of whether or not a given case was consistent with accepted practice can only be made subjectively. Peer review systems are notorious for their broad definitions of acceptable practice and their reluctance to apply sanctions against offending practitioners. In systems where review is provided by third parties, such as in some utilization review schemes, criteria are usually circular or tautologous, as are, e.g., criteria for lengths of stay which are based on the distribution of historical lengths of stay.

The choice between an administered price system such as the one proposed here and alternative systems in which a hodge-podge of regulations and controls are superimposed on cost-based reimbursement in attempts to counteract the perverse consequences of the incentives inherent in cost-based reimbursement boils down to a choice between a system which is based on objective criteria and which will operate automatically once properly established vs. systems which are founded on vague and ill-defined notions of need or propriety and which require the application of subjective and discretionary human judgment on a case-by-case basis. Because of its basic simplicity, the fact that price determination is the only function required of it, and because no supplementary regulatory mechanisms are required in conjunction with it, the administered price system will require a minimum resource expenditure for its maintenance. In contrast, the resource cost required to continually plan, regulate, police, and confound the operation of a health system based on reimbursement of "reasonable" cost is extremely large; additional costs associated with inefficiencies resulting from non-price rationing, misjudgments, and the perpetual turmoil created by such systems is incalculably large.

The design and implementation of a price system which has the three basic properties discussed in this section must be undertaken in a series of steps which are discussed in the following sections of this paper. These steps are approached as distinct phases of empirical research and development, primarily because adequate data and information upon which to base an administered price system are lacking at this time. These data must be developed to serve the requirements of the system as it is designed and implemented on the basis of presently available information. It is the use of such presently available information in a research agenda which we now propose.

The agenda consists broadly of the following four stages. First, we proceed to establish groups of hospitals within which uniform prices can be validly imposed. The methodology of this grouping and classification of hospitals is treated in the next section. Second, we undertake the determination of the initial sets of prices to be imposed within the groups of hospitals determined in the first step. These prices are based on estimates of the necessary and efficient costs of producing the alternative case types within each group of hospitals. The estimation procedure to be used in this second step of the research is discussed in Section IV. The third step of the research program is devoted to establishing more suitable definitions and measurements of the variables which were used in the research of steps one and two. These include the definitions and measurement of facilities and services provided by hospitals, of case-type, and of variables used to characterize the economic environments of health service institutions. These newly devised definitions and measurements are then incorporated into the design of the reporting systems which will be used by the health service institutions within the administered price system. The fourth step of the research agenda is devoted to the specification of the rules by which the administered prices are revised. The rules are based on a "symptomatology" of market information which indicates whether prices should be increased or decreased by the rate administrator. The application of the rules may require additional information which can be added to the reporting requirements of health service institutions.

III. GROUPING HOSPITALS FOR COMPARISONS OF ECONOMIC EFFICIENCY

In this section we discuss the principles for grouping hospitals. The purpose of the grouping is to classify hospitals in a way affording the determination of a single set of prices for each group which represents the minimum necessary marginal costs of production. The major problem to be addressed in this section is that regarding the appropriate criteria for use in differentiating and assigning hospitals to categories within which their relative efficiencies can be validly compared and within which a single set of prices can be validly imposed. This problem includes questions regarding the variables to be used as the basis for the grouping, the definition and measurement of those variables, the definition of a proper group, and the method to be used to accomplish the clustering. These questions will be addressed in this section. Before dealing with these questions, however, we will devote the next few paragraphs to discussion of the notion of efficiency and the problems of directly identifying inefficient hospitals through the use of statistical techniques of empirical analyses.

THE COMMONWEALTH OF MASSACHUSETTS,
EXECUTIVE DEPARTMENT,
Boston, Mass., May 21, 1976.

Hon. CHARLES A. VANIK,
Ways and Means Subcommittee on Health,
Rayburn House Office Building, Washington, D.C.

DEAR REPRESENTATIVE VANIK: I am pleased to forward to you a "White Paper on Health Care Expenditures in Massachusetts" which was developed at my request by the Health Planning and Policy Committee of the Commonwealth to document the rapid rise of costs and expenditures in the health field in Massachusetts. The paper also presents a number of specific proposals to address this problem.

I believe this paper represents a significant initiative in analyzing health expenditures at the state level and in developing a comprehensive approach to rising health care costs. The paper is being distributed widely to facilitate a broad public debate of the complex issues raised by rising costs in the health field.

Over the next few months we will be refining the proposals and developing plans for their implementation. We would welcome any comments or suggestions which you or members of your staff might offer.

I hope the enclosed document will be useful to you. If you or members of your staff would like to discuss this paper, please feel free to call me or Lieutenant Governor O'Neill's Office of Federal-State Relations in Washington.

Sincerely,

MICHAEL S. DUKAKIS, *Governor.*

HEALTH CARE EXPENDITURES IN MASSACHUSETTS [1]

A WHITE PAPER DEVELOPED BY THE HEALTH PLANNING AND POLICY COMMITTEE OF THE COMMONWEALTH, APRIL 30, 1976

VII. POLICY PROPOSALS

(1). Determination of Need

A major mechanism for preventing an excess in the supply of health services in the Commonwealth is the Determination of Need program (DON).

The DON program is designed to provide public review over facility construction and expansion decisions in order to ensure that they will contribute to improved quality and accessibility of needed services at the lowest aggregate cost. The required reviews operate in several ways to hold down costs of health care. First, the Public Health Council responsible for making determinations of need can disapprove a proposed project for which need has not been proven, thus blocking its implementation. Second, the process of regional planning and analytical review which underlies DON reviews can result in reductions in the scope of expansions, or in significant changes to provide for greater benefit at less cost. Third, the requirement for review by the public agency acts as a disincentive so that some projects envisioned by providers are not even proposed for DON approval. Finally, and perhaps most importantly, the program has significant impact in fostering a sharing of services and resources among institutions.

A recent study of DON decisions in Massachusetts concluded that the program "forestalled the addition of 478 beds in the general hospital sector and 1885 long term beds." [35] These figures reflect a savings of at least $280 million in construction costs since 1972. Had these projects been implemented the estimated impact on total health expenditures would have been an additional expenditure of $127,250 per day, or almost $46.5 million a year.[36]

While the determination of need program has led to substantial savings in total health care expenditures in Massachusetts, it lacks authority in two critical areas. First, although the program is able to monitor major expansion of health resources by hospitals and clinics, it does not have similar authority over capital acquisitions by individual doctors or groups of doctors. Increasingly groups of physicians in private practice are acquiring expensive equipment which, if purchased by a hospital, would be subject to DON review.

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[1] Edited by Oversight Subcommittee staff. Footnotes original.
[35] Bicknell, William J., M.D., and Diana Chapman Walsh, M. S. "Certification of Need: The Massachusetts Experience," *New England Journal of Medicine,* May 15, 1975, p. 1054.
[36] Massachusetts Department of Public Health, Boston, Massachusetts.

A current example of this trend is the CAT scanner, a sophisticated and expensive device used primarily to detect neurological problems. Health planners generally agree that there is a limit to the number of scanners required in any given area, and that oversupply will lead to unnecessarily high utilization and unnecessary costs. Because the per patient charge is fairly high, overuse could lead to significant increases in health costs. While hospitals and state-licensed clinics must obtain a determination of need before purchasing a scanner, it is difficult to prevent an oversupply of scanners due to purchases by individual physicians. Unless the DON program is expanded to include such purchases, costs are likely to continue to rise needlessly.

A second limitation on the determination of need program as a mechanism for constricting supply is that the program only examines proposals for new construction or replacement; it has no authority to examine the necessity or appropriateness of services already being provided in an area.

A third limitation in the past has been the lack of uniformity in standards used by various agencies in reviewing DON applications. The state is currently working with the newly formed Health Systems Agencies to alleviate this problem by developing uniform standards and criteria to be applied in reviewing the broad scope of services covered under the Determination of Need Program.

Proposals

(a) To permit more effective regulation of major acquisitions, the determination of need program should be expanded to encompass acquisition of major pieces of equipment by physicians as well as institutions.

(b) To begin to deal with existing services, a mechanism has been proposed to link reviews of the appropriateness of existing services with the state's rate-setting process. These reviews, required under the federal Health Planning and Resources Development Act of 1975, will be conducted by the regional Health Systems Agencies with strong participation by local consumers and providers.

2. Hospital Charge Reviews

In July 1975 the Governor signed into law Chapter 424 of the Acts of 1975, establishing an interim system for reviewing proposed changes in hospital charges. Under the legislation the state's Rate Setting Commission reviews changes in hospital charges effective after April 15, 1976. As of January 8, 1976, the Commission had reviewed 115 budget submissions for 1976, disallowing over $10 million in 1976 budgeted cost increases and over $3 million in proposed revenue increases due to increased charges for services.

While the interim system established under Chapter 424 has apparently had some impact on hospital charge increases, it is inadequate in two important respects. First, it permits differing charges to be billed to different classes of payors, a situation which severely limits the ability of any one payor to constrain rising hospital prices. Second, like the determination of need program discussed above, it only addresses new or increased charges, rather than authorizing review of costs incurred and amounts charged in the base year.

Proposal

(a) To meet these inadequacies the Governor has filed legislation establishing a more comprehensive system of charge control. Under the proposed legislation, H. 3160, all patients at a hospital would be charged the same amount for the same services; hospital revenue would be limited to the amount necessary to provide needed services; and the public would be brought into the entire rate setting process through the new regional health systems agencies (HSAs), as well as through the public hearing process of the Rate Setting Commission. The HSA's, as they demonstrate the capacity, would review services offered by hospitals in their region as mandated by federal law, and their determinations would provide the basis for the Rate Setting Commission to disapprove charges for services deemed inappropriate.

By linking rate setting and planning functions, the bill would establish a mechanism for 1) eliminating oversupply of services which tend to drive up costs, and 2) encouraging more effiecient operation of those services which are in fact necessary and appropriate in the judgment of the community to be served.

3. Quality Assurance

While DON and the hospital charge control system should be effective in constricting the supply of services, their long term effectiveness in limiting overall costs depends on their being linked with effective programs of quality

assurance. For example, utilization review (UR) programs are charged with reviewing cases of hospital and nursing home patients to determine whether they are receiving the level of care they need in the respective institution. The object of utilization review is to identify persons who are receiving inappropriate treatment, whether too much or too little, so that steps may be taken to ensure that appropriate treatment is provided.

Several major UR programs now operate in Massachusetts: Most hospitals in the state, in order to qualify for accreditation by the Joint Commission on the Accreditation of Hospitals, conduct some type of utilization review for all patients and are also required to do in-depth audits of the quality of care for selected classes of problems. In addition, the Certified Hospital Admissions Monitoring Program (CHAMP) monitors services delivered in hospitals to patients receiving Medicaid. Since its inception in 1973 CHAMP has reviewed approximately 200,000 cases, leading to approximately $15 million in savings to the Medicaid program.[37] Over the next year CHAMP will be phased out as the federally established Professional Standards Review Organizations (PSRO's) undertake reviews of hospital cases paid for by either Medicare or Medicaid. While the PSRO's are relatively new agencies, they have the potential for conducting CHAMP type reviews for all Medicare and Medicaid patients in Massachusetts hospitals. In addition, PSRO's will be required to conduct in-depth studies of the quality of care being provided to patients receiving federal funding for hospital services.

A second major quality review program is the Periodic Medical Review program (PMR), which by federal requirement entails annual reviews by the Department of Public Health of the records of all Medicaid patients in skilled nursing facilities and state mental hospitals. These reviews are carried out by nurses and other trained personnel under physician supervision, and attempt to determine whether patients are receiving adequate nursing care and whether patients are in the appropriate institution in terms of care provided.

The Independent Professional Review (IPR) program conducts similar reviews annually of cases in intermediate care facilities.

The impact of effective quality assurance on expenditures is evidenced by recent PMR analyses which indicate that about 18 to 20% of Medicaid patients in skilled nursing homes in fact do not need the level of Medical care delivered in those settings, and could be well cared for in the less expensive intermediate care facilities. If these residents could be moved to a less intensive setting, the average savings per patient would be about $1,825 per year.[38]

Proposals

(a) Quality assurance activities conducted through the PSRO's should include all hospital patients covered by any third party payor. In addition, the state should encourage PSRO's to review the efficiency of medical practice and to deal with such issues as patterns of utilization of lab and X-ray procedures. Over time this should be expanded to include peer review of long term care and ambulatory care.

(b) The state will explore the possibility of requiring pre-admission reviews for all nursing home residents. Since institutional care my be unnecessary if adequate alternatives are available, these reviews should be conducted by individuals who are thoroughly familiar with the range of resources available in the area.

(c) The state will develop an effective system for monitoring the utilization review activities of PSRO's .

(d) The state will take an active role in encouraging shared use of data developed by PSRO's and other agencies as necessary for comprehensive quality assurance activities.

(e) The state will develop or encourage others to develop pilot programs using techniques which have proven effective elsewhere in promoting appropriate use of health services. One such technique is the "second opinion option," in which third party payors agree to reimburse the patient for the costs of obtaining a second physician's opinion in regard to elective or non-emergency surgery.

(f) The state in consultation with the Massachusetts Medical Society and other appropriate groups, will explore approaches to ensuring the continuing professional competence of physicians and other health professionals registered by the Commonwealth.

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[37] Massachusetts Department of Public Health, Boston, Massachusetts.
[38] Massachusetts Department of Public Health, Boston, Massachusetts.

(g) The state will encourage the development of community based alternatives to institutional care, particularly for the elderly and persons discharged from mental hospitals. Identification through utilization review of patients able to live outside the institution is of little value if the lack of community resources—including adequate housing, health services, and general household services—prevents the person's returning to the community.

4. Prepaid and Group Medical Practice

Among the more promising mechanisms for reducing demand for health services, particularly demand for high cost services, are the various forms of prepaid medical practice exemplified by the Health Maintenance Organization (HMO), discussed briefly above. In such an organization individuals pay a fixed fee (similar to an insurance premium) to the provider organization which is then responsible for providing directly or through contractual arrangements with other providers a predetermined range of health care services. The range of services covered is generally broader than under traditional health insurance policies, usually including ambulatory and preventive as well as acute services. Since the income generated from the fixed premiums does not vary with the cost of services actually delivered, the physician or other provider accepts some of the financial risk usually left to the consumer. This provides strong incentive for physicians to be very judicious in the use of services and encourages efforts to keep patients out of hospitals whenever possible.

Several recent studies indicate that both hospital utilization rates and total expenditures for health care are significantly less for persons enrolled in prepaid plans than for those carrying traditional health insurance. A recent survey of HMO's across the country reports that cost savings average about 20%, even after such variables as differing populations and out-of-plan expenditures are taken into account.[39]

Although HMO's and other prepaid plans hold promise of significant cost reductions, legal and administrative barriers have constrained their development in Massachusetts. Legislation is currently under consideration by the General Court which would remove many of these obstacles by defining the legal characteristics and liabilities of an HMO and assigning regulatory authority over such organizations to the Commissioner of Insurance.

A second delivery model which holds promise of proving high quality care at lower costs is the multi-specialty group practice. Given the high degree of specialization currently in effect in the medical profession, it is important to note that this model appears to be associated with more cost effective care and lower rates of hospital utilization than are non-group, specialist-oriented practices.[40] Preliminary studies indicate that these effects occur independently of whether the group practice operates on a prepayment or fee-for-service system.

Proposals

(a) The Commonwealth should enact legislation clarifying the legal status and the state's expectations of prepaid groups practices and HMO's.

(b) Regulatory mechanisms should be established which will provide as much flexibility as possible to developing HMO's and other prepaid plans, while protecting the consumer through safeguards on financial solvency, high quality medical care, and guarantees of alternative coverage in the event the prepaid plan terminates.

(c) The state will undertake administrative efforts to encourage the formation and development of HMO's, including provisions of technical assistance and possible funding mechanisms.

(d) The state will investigate the performance of multi-specialty group practices to ascertain whether they exhibit any generalizable patterns in providing high quality services at relatively low price. If such patterns are apparent, the State will explore mechanisms to facilitate the development of such practices in the Commonwealth.

5. Health Insurance

In addition to clarifying the legal status of health maintenance organizations, the Commonwealth needs to reexamine the impact of traditional health insurance coverage on the cost of medical care. In recent years, legislative initiatives have

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[39] Starr, Paul, "The Undelivered Health System," *The Public Interest*, Number 42, Winter. 1976, p. 70.

[40] Ellwood, Paul, Statement before the Subcommittee on Health and Environment, United States House of Representatives, Washington, D.C., February 10, 1976.

led to statutory requirements for certain types of benefits, notably alcoholism treatment and mental health services, to be included in major medical policies. Legislation has now been introduced which would require minimum standards of health insurance coverage. Both these approaches have significant implications for both the availability and the cost of health care.

Regulatory authority in the Commonwealth is divided among the Division of Insurance, the Rate Setting Commission, and the Group Insurance Commission. Until recently, no formal mechanism existed to ensure that the implications of insurance regulatory decisions were related to health policy objectives. The Health Planning and Policy Committee now provides such a forum, facilitating coordination of insurance regulation and health policy.

Proposals

(a) The Commonwealth will define specific ways by which regulatory authority in the field of health insurance should relate to the development and implementation of health policy. In the course of such definition, the state will address specifically the types of information now available to the Commissioner of insurance and ways of developing a more complete data base to explore the impact of insurance policies on health care costs.

(b) The Commonwealth, working with representatives of the private insurance industry, will explore new approaches to controlling costs in the health insurance area, including an analysis of current and proposed mandates for coverage.

(c) The state will further encourage the private health insurance companies and other third party payors to develop experimental or demonstration projects to test the effect of different reimbursement policies on utilization, particularly in the hospital sector. Such efforts should focus on ambulatory surgery, preadmission ambulatory testing, outpatient work-up facilitators, and alternative ways of linking hospitals with long term care facilities.

6. Hospital Consolidation

The determination of need discussion above notes the important role played by that program in fostering cooperation and sharing of services among institutions. In the past statutory and administrative barriers have severely limited coordination and sharing of services between the institutions operated by the Department of Public Health, which operates hospitals, and the Department of Mental Health, which administers both hospitals and schools for the retarded.

In 1975 a major obstacle was removed when the General Court approved legislation permitting the Department of Mental Health to transfer appropriate patients to Department of Public Health hospitals. This statutory change paved the way for both complete and partial consolidation of facilities, involving Gardner State Hospital and Rutland Heights, and Boston State Hospital and Lemuel Shattuck Hospital. These efforts will have two specific types of benefits. First, they will enable the state departments to provide better medical and psychiatric care for the patients. Second, they will increase the federal revenues generated by the hospitals by broadening the base of patients eligible for Medicaid and Medicare reimbursement at facilities which meet federal and state standards.

Proposals

(a) The Commonwealth will develop a clear definition of the roles which state-sponsored institutions should fill in terms of the total health needs of the Commonwealth.

(b) The Departments of Public Health, Mental Health and other relevant agencies should develop a coordinated plan for implementing those roles, including the partial or total consolidation of state owned institutions as appropriate. Legislative and administrative changes should be initiated as required to implement those plans, following adequate public review and consultation with affected parties.

7. Health Manpower

Massachusetts enjoys a relatively high ratio of physicians to total population, currently estimated at 214.8 physicians per 100,000 residents as compared to a national rate of 167.4 per 100,000.[41] This ratio reflects in part the concentration of training resources in the state, including four medical schools and 14 hospitals with comprehensive teaching programs.

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[41] Enthoven, Alain C., Can We Control the Cost of Health Care," *The Stanford Magazine*, p. 15. (Volume number and date unavailable.)

While the overall ratio is quite high, the Commonwealth shares with most other states the problem of maldistribution in terms of both geography and specialty. The ratios of physician to population within each of the state's six health systems areas range from 93.4 per 100,000 to 360.1 per 100,000 residents.[42] Only about one-third of the physicians in the state provide primary care. The others are specialists who provide highly specialized or tertiary care to patients referred to them by primary care physicians. One effect of low physician ratios is a tendency for residents to use the emergency rooms of community hospitals for routine medical care.

While the state has relatively little authority in the areas of physician training and distribution, it is working through the new University of Massachusetts Medical School to increase the number of primary care physicians practicing in Massachusetts. In qualitative terms, some of this training will focus on unmet needs such as medical services in public institutions. Efforts are also underway to develop better information on health manpower resources in the Commonwealth, an area which until recently received relatively little attention from the public sector.

Proposals

(a) The state will focus available resources, including training resources of the new University of Massachusetts Medical School and Teaching Hospital, toward improving the current imbalance of medical specialization.

(b) The state will explore ways to foster better distribution of specialists and to encourage redistribution of available manpower to ensure adequate care for persons living in both rural and urban areas in the state. These efforts will be linked closely to the development and implementation of state and regional health plans.

(c) The state will support the development of the allied health professions with the aim of providing an optimal mix of health professionals to meet the needs of the Commonwealth.

(d) The state will continue its efforts to develop a comprehensive data base on health manpower, in coordination with institutions engaged in training health professionals, health planning agencies, and other interested organizations.

8. Regulation Review

While one answer to rising health costs may be increased regulation by government authorities, it is clear that such regulation must take into account the cost of regulation compliance. In recent months the Commonwealth has initiated reviews of various nursing home regulations to evaluate their impact on the quality of patient care relative to the costs incurred in implementation.

In addition to reviewing state regulations, the Commonwealth has worked with HEW to permit consideration of cost benefit analysis in decisions regarding federal regulations. This approach has been particularly important in the area of nursing home regulation, where federal guidelines have tended to focus on physical plant requirements rather than on patient needs or quality care. In a recent round of negotiations, Massachusetts obtained tentative HEW acceptance of a flexible interpretation of federal Life Safety Code regulations which will save an estimated $100 million in nursing home construction costs which would have been required under strict enforcement of original federal guidelines.

Proposals

(a) State officials will continue to review existing regulations to identify overlapping or contradictory regulations and to determine whether regulations produce sufficient benefits for patients to justify the expenditures required for compliance. The state will also review the costs created by proposed regulations before issuing any regulation in final form.

(b) The state will continue to push the federal government to streamline its regulations to permit an optimal balance of costs and benefits in the delivery of health care.

9. Generic Drugs

In 1970 Massachusetts enacted the first state generic drug law. The law requires that physicians who prescribe by brand name shall also include the generic or chemical name of the drug, if any, on the prescription. Generic drugs, equivalent to brand name drugs in composition and effect, generally sell at substantially

[42] Massachusetts Department of Public Health, *Health Data Annual, 1975,* Volume II, Number 1, Boston, Massachusetts, 1975, p. 36.

lower costs than do their trade name counterparts. U.S. Senator Gaylord Nelson reported in 1973 that generic drugs generally cost from ½ to 1/30 as much as brand names.[43] In 1973 the Massachusetts Department of Public Health estimated use of generic drugs rather than brand name drugs would yield a savings of $1.5 million to the state's medical assistance program, and a total savings of from $4.4 to $7.0 million to consumers throughout the state.

Proposal

Legislation has been introduced in Massachusetts which would facilitate use of generic drugs by requiring physicians to use prescription forms with two alternative places for signature. If the physician indicated by his or her signature that the pharmacist filling the prescription should substitute the lower cost equivalent drug, then the pharmacist would be legally required to do so. The Administration has endorsed the principles of the bill and urges its passage by the General Court.

10. Health Planning

Further development and effective implementation of many of the proposals discussed in this paper depend in large part on a strong, effective health planning process for the Commonwealth. Since 1967 the regional health planning agencies (the "b" agencies) and the state's Office of Comprehensive Health Planning (the "a" agency) have had the primary responsibility for health planning in the Commonwealth. While these agencies have provided valuable planning resources and leadership to the health field, their affectiveness, particularly at the regional level, has been limited by a lack of sufficient financial resources and their status as primarily advisory agencies.

In 1975 federal legislation (P.L. 93–641, the National Health Planning and Resources Development Act of 1975) mandated the establishment of new Health Systems Agencies (HSA's) and a State Health Planning and Development Agency to replace the "b" and "a" agencies as official health planning bodies. In Massachusetts HSA's have been designated in four of the six health services areas in the state; designation of HSA's in the two remaining areas is expected in the summer of 1976.

In the coming years these HSA's must address some very complex issues of health resources development and utilization, including such issues as physician distribution, coordination of institutional resources, and allocation of limited health dollars. The state's health planning system must have the capacity to perform in-depth analyses of these issues, if it is to provide the direction needed to ensure effective, efficient use of the state's abundant health resources. Two elements are essential to the development of this planning capacity. First, the planning agencies must have adequate funding. Second, the lankage of planning agencies with providers and regulatory agencies must be clearly defined.

Unfortunately, in both these areas federal support has been inadequate. P.L. 93–641 fails to clarify the relationship between the HSA's and other elements of the health system and to provide the authority needed to give planning recommendations more weight than simple advisory opinions. Further, the level of funding provided to the HSA's in recent federal appropriations is so low that in Massachusetts the new agencies will receive even less funding this year than did the predecessor agencies last year. Unless additional resources are made available, the planning system will not be able to carry out its functions effectively in the coming years.

Proposals

(a) The Commonwealth should continue its efforts in conjunction with the HSA's to obtain additional federal funds for the Massachusetts HSA's. The higher than average level of resources and larger proportion of expensive, highly specialized services in Massachusetts demand an increase in the financial resources designated for planning and coordinating the medical care system in the state. Particular efforts should be made to increase the HSA's capacity to perform economic analyses.

(b) The Commonwealth should develop, in consultation with all concerned parties, and define by law or regulation the specific linkages between the planning agencies and other components of the health care system. Incorporation of planning agency reviews in the proposed hospital charge regulation system is a critical element in this process.

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[43] Nelson, Gaylord, Statement before the United States Senate, Washington, D.C., June 11, 1973.

(c) The Commonwealth will develop a common format for state and regional health plans to facilitate integrated planning. The state's health planning and development agency will coordinate input of regional planning agencies to develop integration of regional and statewide objectives into a single, comprehensive state plan for approval by the state's Health Coordinating Council, established under P.L. 93–641.

(d) The Commonwealth will use both delivery and regulatory mechanisms to achieve the specific objectives adopted through the state health plan.

11. The Federal Role

Most of the proposals discussed here focus on the Commonwealth—its government, health providers, consumers, and others. But any actions taken here occur in the context of a federal system, in which decisions by the federal government have significant impact on the availability and cost of health services in the Commonwealth.

It is essential, therefore, that representatives of both the public and private sectors in Massachusetts be aware of initiatives at the federal level and work to ensure that such actions serve the best interest of the people of the Commonwealth. Toward this end the following proposals for federal action are included here.

Proposals

The state will urge the federal government:

(1) to continue and strengthen federal initiatives in the health field, including PSRO's, Health Systems Agencies and other planning bodies under 93–641, HMO's, and manpower development and distribution efforts;

(2) to build upon state initiatives and to incorporate successful state efforts in such areas as hospital charge reviews and utilization review into national programs;

(3) to consider replacing federal regulations, particularly in the area of long term care, with more flexible standards, permitting states to define specific requirements.

(4) to move toward a program of national health insurance which reinforces successful programs and includes effective, state-oriented mechanisms for controlling costs;

(5) to refrain from responding to the pressures of rising costs by retrenching and placing an increasing burden on the states and local governments.

12. Primary Prevention and Individual Health

While the various proposals discussed above should be pursued as means for bringing the rate of cost increase under control, the most obvious response to rising health costs is, of course, to reduce illness. Ironically, the most effective measures for limiting health costs are probably related to medical care only peripherally. Much illness is caused by poor individual habits and often times medical care cannot undo what the individual has done to him or herself.

For example, in Massachusetts in 1974 auto-related accidents were the direct cause of more than 72,000 non-fatal injuries, almost 13 for every 100 persons in the Commonwealth.[44] The use of seat belts reduces the risk of fatal accidents by at least 50%, yet their use is still not required. Of the leading causes of death in the Commonwealth other than auto-related accidents, several are linked directly to poor eating habits, lack of physical exercise, and environmental pollutants.

Programs to discourage individuals from smoking, improve driving habits, strengthen drunk driving laws, improve the environment, promote physical fitness and good nutrition—all could improve the quality of individual health in Massachusetts and impact rising costs far more than could specific medical programs. Further, the State should consider enacting and enforcing much more stringent laws in those areas which clearly affect the public's health. One example of this approach is Sweden's mandatory seat belt law, which requires police to ticket any person seen not wearing a seat belt in a moving vehicle.

Until individuals and society as a whole begin to practice preventive medicine on a large scale, other attempts to limit health care expenditures will be of only limited success.

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[44] Massachusetts Department of Health, *Health Data Annual, 1975,* Volume II, Number 1, Boston, Massachusetts, p. 29.

Proposal

The state will develop a comprehensive program of preventive health and will work with communities to develop and replicate models for improving individual health. Attention will be focused on improving dental health, limiting environmental pollutants, promoting programs to assist individuals to stop smoking, improving screening for hypertension and other major health problems. The program will include local initiatives involving health education and local boards of health activities, use of the mass media to encourage healthful personal habits, and a legislative program aimed at primary prevention.

Technical Note.—Data on hospital expenditures in Massachusetts are derived primarily from the Massachusetts Funds Flow Project, an interagency project initiated in 1975 by the Massachusetts Department of Public Health, Rate Setting Commission, Department of Public Welfare, and Office of Comprehensive Health Planning. The method used is essentially that devised by Cooper and Worthington (Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education and Welfare). The Department of Public Health and Rate Setting Commission provided data on expenditures for hospitals, nursing homes and other non-federal facilities.

Additional data was collected from federal sources and the private sector. Out of pocket expenditures were estimated as a residual after all private and public third party expenditures were subtracted from total health expenditures, estimated independently.

Figures for FY 1969 and 1973 are actual expenditures; analogous figures for FY 1975 and FY 1976 reflect Fund Flow Projections unless otherwise indicated.

The Funds Flow Project is currently developing actual data for FY 1974, 1975, and annual projections through FY 1977. The methodologies used are continually refined. Estimates and comparisons of 1969 through 1973 may be revised in accordance with such refinement to ensure comparability.

Additional information on the funds flow methodology, analyses and results not discussed here is available from the Office of Comprehensive Health Planning, Massachusetts Department of Public Health, 600 Washington Street, Boston, 02111.

ADMINISTRATION OF MEDICARE COST-SAVING EXPERIMENTS

MONDAY, MAY 17, 1976

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met at 2:30 p.m., pursuant to notice, in room H–208, the Capitol, Hon. Richard F. Vander Veen presiding

Mr. VANDER VEEN. We are going to do something unusual and begin a congressional hearing a minute before it is scheduled to start. That may set an all-time record. I don't know.

We expect a lot of people here this afternoon, and we may have a little difficulty crowding in, but we have a great many subjects to cover. We are going to ask the witnesses to do their best to condense their statements so that we can make the appropriate inquiries. I am going to lead off with a statement which I will try to summarize with respect to the purpose of this hearing and why we are gathered here today.

During the past year, the Oversight Subcommittee has attempted to monitor the Department of Health, Education, and Welfare research on medicare and health cost-saving experiments. The subcommittee believes that these experiments may hold the key to urgently needed improvements in cost control and quality in Federal health care programs.

Increasing Federal and State participation in the delivery of medical care, mounting pressures for national health insurance and escalating health care costs—up 300 percent in the past decade and now amounting to $118 billion yearly—underline the need for new cost effective health care policies.

The subcommittee staff has found evidence that indicates HEW has not developed adequate new cost-containment procedures, due to a lack of vigorous and timely experimental effort.

Congress has provided the Department with both the money and authority to test a broad range of health care experiments.

To date, the development and performance of the experimental projects has seriously fallen short of the expectations and goals of the Congress. Nearly 4 years after the enactment of Public Law 92–603 and the expenditure of over $20 million under the social security research provisions, no detailed recommendations have been made with respect to implementing specific methods tested.

The entire effort at experimentation has been exceedingly slow.

In sum, there has been a loss of opportunity to develop more efficient and economical methods of health care financing and delivery of services.

Today's hearing focuses on three projects, durable medical equipment, day hospital services and physician extender experimentation, where this loss of opportunity is particularly obvious.

In addition, poor performance in these and other research activities of HEW indicates a questionable administration of the entire experimental effort. Evidence gathered by the subcommittee reveals a serious lack of coordination between the Social Security Administration and the Public Health Service in the assignment of section 222 responsibilities. The shifting of projects from one agency to the other, as well as a longstanding budgetary dispute between SSA and PHS have taken away a great deal of valuable time from experimentation efforts. It is my hope that our hearing today will ensure improved coordination within HEW on the administration of research projects and the use of research funding.

The failure of the Secretary of HEW to formally delegate section 222 responsibility to the appropriate divisions within the Department has contributed to a disorganized implementation of the law. For example, according to a March 19, 1976 Social Security memo from Elmer Smith, associate commissioner for program, policy and planning, "No formal delegations of authority have been made by the Secretary for implementation of any of the areas of experimentation specified in Section 402(a), as amended, or in Section 222."

In a letter of March 26, I requested that Secretary Mathews decide just who is responsible for the various section 222 experiments and demonstration projects. No response has been given to this urgent question. It is our hope that today's testimony from the administration witnesses will resolve this issue once and for all.

No single research project can solve our nation's health cost problems, but the incredible continuing inflation in health service costs requires that we give more attention to new and better ways of providing and financing services.

I would now like to introduce the witnesses who will testify before the subcommittee today.

The witnesses will be:

Marjorie Lynch, Under Secretary, Health, Education, and Welfare.

Commissioner CARDWELL. Mr. Chairman, it may be that she has another understanding on the time of the hearing.

Mr. VANDER VEEN. I see. Mr. James B. Cardwell has just spoken. He is the Commissioner, Social Security Administration.

Dr. Theodore Cooper, Assistant Secretary for Health.

Commissioner CARDWELL. I assume he will be with the Under Secretary.

Mr. VANDER VEEN. Mr. Jarrett Wise, director, physician's assistant program, George Washington University, School of Medicine and Health Sciences.

Mr. Gregory Ahart, GAO.

Mr. Robert Iffert, assistant director, manpower welfare division, GAO.

Dr. Carole Steinbock, director of the center for social research and rehabilitation medicine, Albert Einstein College of Medicine, Bronx, New York.

Before we begin, I should like to point out that members of the subcommittee may be called away to vote at any time, although we are struggling with a series of consent bills now, and there are no votes on the floor. But that may occur. In an effort to avoid prolonging this hearing, I would like to ask that in the testimony given you cover the highlights of your statement, and without objection, your written testimony will be entered in the record in its entirety.

Mr. Ahart, since you are here, woud you now proceed.

STATEMENT OF GREGORY AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, GAO, ACCOMPANIED BY ROBERT IFFERT, ASSISTANT DIRECTOR, MANPOWER AND WELFARE DIVISION, GAO

Mr. AHART. Mr. Chairman, and members of the subcommittee, we are pleased to appear today to discuss the need for improvements in providing durable medical equipment to medicare beneficiaries.

On May 12, 1972, we issued a report to the Congress entitled "Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare." In that report, we discussed how medicare patients often rented durable medical equipment even when the periods of need, as estimated by their physicians, were long enough to justify purchase.

During our review at 5 medicare carriers in 4 States, we analyzed a statistical sample of patients' claims selected from the claims of the 13,000 patients whose claims for durable medical equipment were processed in 1970. For the 13,000 patients, GAO estimated that $234,000—including the patients' share of $47,000—could have been saved if the equipment had been purchased when the anticipated periods of need indicated that purchases would have been more economical than rentals.

At a sixth carrier in a fifth State, we analyzed a sample selected from the claims of the 7,000 patients whose claims were processed during August 1971. For the 7,000 patients, we estimated that savings of $763,000—including the patients' share of $153,000—could have been realized.

In our report, we recommended that the Congress amend the medicare law to authorize HEW to find more economical methods for paying for durable medical equipment including authority to: Make lumpsum payments for purchases of equipment when, on the basis of anticipated periods of need, purchase appears to be more economical than rental; require the early submission of such claims; and limit payments to the amounts payable under the recommended rent-or-purchase decision. Enter into agreements with suppliers aimed at limiting rental payments after they exceed the purchase prices by specified percentages and at obtaining prices for the purchase of equipment that are comparable to those obtained by other federally-financed health programs.

Accurate data on medicare expenditures for durable medical equipment and on the potential overall savings through purchasing rather than leasing such equipment are not readily available.

The Social Security Administration estimates that in calendar year 1973, about 1.9 percent of total part B medicare payments were for durable medical equipment. We have no reason for questioning this estimate. Based on this estimate, medicare's durable medical equipment costs would have totaled about $47 million in fiscal year 1973 and about $62 million in fiscal year 1974. These estimates of program costs, excluding beneficiaries' copayment liabilities, should provide some frame of reference to judge the reasonableness of any estimates of potential savings.

At the request of the Human Resources Task Force of the House Committee on the Budget, we developed an estimated savings by purchasing rather than leasing durable medical equipment of about $14 million of which the medicare program share was about $11 million, for 1970. That estimate is based principally on work performed several years ago and, as we advised the task force, is not statistically valid. It may serve, however, to give a rough idea of the magnitude of potential savings.

In line with the recommendations in our 1972 report, section 245 of Public Law 92–603 authorized the Secretary to conduct experiments designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment including purchase if justified by the anticipated length of rental. The Secretary was also authorized to implement on a nationwide basis any reimbursement procedures developed in these experiments.

HEW issued a request for proposal for designs for such experiments in December 1973. Three proposals for testing new reimbursement methods were developed under that procurement. The reimbursement methods proposed in these protocols were: (1) a prepaid capitation system, (2) a system to automatically transfer title to the beneficiary when rental payments exceed the purchase price plus an additional rental payment, and (3) a system which included lump-sum payments for new and used equipment, and a rental-purchase conversion procedure.

On May 14, 1976, the Social Security Administration requested competitive proposals for conducting an experiment based on the latter proposal.

With regard to rental-purchase, the request for proposal provided that: Rental-purchase conversions occurring during the first 6 months of rental shall have at least 1 month's rental deducted from the purchase price;

Rental purchase conversions occurring during the seventh month and thereafter shall have, in addition to the reduction allowed for the first 6 months, at least 2 percent of the original purchase price credited for each month, beginning with the seventh month, up to a maximum reduction of at least two-thirds of the purchase price.

Thus, it could take over 2½ years to attain a two-thirds credit toward the purchase price. However, some limited work we recently performed shows that the purchase price of durable medical equipment is generally less than 1 year's rental costs.

We understand that SSA expects to award a contract by about July 30, 1976. The request for proposal provides that the experiment effort shall be completed within 3 years.

Thus, assuming that the experiment is not completed before the maximum time and that the Social Security Administration does not implement changes in reimbursement procedures during the experiment, at least 7 years will have passed since the enactment of section 245 of Public Law 92–603 before the reimbursement improvements envisioned in that legislation are implemented.

We believe that our 1972 report demonstrated the economic benefits available from the use of lease-purchase agreements for durable medical equipment. A bill, H.R. 8717, introduced on July 17, 1975, would require the Secretary to enter into lease-purchase agreements with suppliers and to encourage the use of lease-purchase agreements for durable medical equipment. In a February 11, 1976, report to the Human Resources Task Force, we recommended that the Congress enact H.R. 8717. We continue to endorse this legislation.

Mr. Chairman, that concludes our statement. We will be happy to answer your questions.

Mr. Vander Veen. Thank you, Mr. Ahart. I appreciate very much the obvious effort to keep your statement concentrated and to the point, and I think before proceeding to questions, we would like to hear from the next witness, who will be Mr. Iffert.

Mr. Ahart. Mr. Iffert accompanies me, Mr. Chairman.

Mr. Vander Veen. I see, and he doesn't have a separate statement. That is fine.

I would like to ask you one question, Mr. Ahart, with reference to hemodialysis equipment. Social Security is excluding the durable medical equipment experiment on hemodialysis equipment. Does the GAO find any justification for this exclusion?

Mr. Ahart. We see no apparent reason for it, Mr. Chairman. The hemodialysis equipment tends to be among the more expensive equipment that is subject to rental. It also tends to be equipment that, assuming the patient adjusts to it properly, is used on a fairly long-term basis. I would see no reason for excluding that.

Mr. Vander Veen. Do you have any idea why SSA does not seem to have accurate data on medicare expenditures for durable medical equipment?

Mr. Ahart. Mr. Iffert may have some response.

Mr. Iffert. It is a very small benefit in terms of the overall benefit, about 2 percent of the total part B benefit. So probably there is no real reason statistically to be constantly breaking down that part of the benefit versus physician services and other benefits. Physician services are over 90 percent of it.

I would guess that probably the current figure for durable medical equipment would be around $100 million.

Mr. Vander Veen. I was struck by one part of your testimony, Mr. Ahart, when you made reference to 7 years having gone by since the enactment of section 245 before the reimbursement improvements envisioned in that legislation were implemented.

Do you have any further comment about that, or do you want to amplify that in any way?

Mr. AHART. It seems to us, Mr. Chairman, that the issues involved here are relatively simple. I think at this point in time we question whether there is a need to get involved in a rather lengthy and complicated experiment. There is legislation before the House which would give the authority necessary to go ahead without experimentation, and we would endorse that legislation, and cut down the time for bringing in the benefits that are available here at an earlier time.

Mr. VANDER VEEN. Thank you, gentlemen, both Mr. Ahart and Mr. Iffert. Thank you very much for your statement, and we will hear from the next witness, Mr. Jarrett Wise.

Mr. Wise, I have identified you and where you come from, but I will say again for the benefit of those who may not have heard that you are, as we understand it, the director, physician's assistant program, George Washington University, School of Medicine and Health Sciences.

Mr. Wise, please proceed.

STATEMENT OF JARRETT WISE, DIRECTOR, PHYSICIAN'S ASSISTANT PROGRAM, GEORGE WASHINGTON UNIVERSITY, SCHOOL OF MEDICINE AND HEALTH SCIENCES

Mr. WISE. Thank you, Mr. Chairman. I appreciate the opportunity to be able to testify before the subcommittee today. Since my prepared testimony is lengthy, I shall not read the entire document but will begin on page 13 which describes the Social Security Administration study, summarizes my statements, and provides my recommendations.

Mr. VANDER VEEN. Please do.

Mr. WISE. Under congressional authority provided in the Social Security Amendments of 1972—H.R. 1, Public Law 92–603, section 222—the Social Security Administration has been conducting a nationwide study designed to address issues concerning how physician extender utilization can decrease the cost of medical care and increase the access to primary care medical services.

This study has been referred to as the physician extender reimbursement study, and plans to make medicare, part B reimbursement, available on an experimental basis to participating noninstitutional primary care practices for services provided by physician extenders to medicare beneficiaries.

The study was awarded to a private contractor in December of 1973. The first part of this award directed the contractor to conduct a literature search and plan a study design for implementation under the second half of the contract.

The study now consists of two phases: the baseline data collection activity and the reimbursement experiment. The contractor and the Social Security Administration, with the complete cooperation of the Association of Physician's Assistant programs and the American Academy of Physician's Assistants has, to the best of my knowledge, completed the baseline data collection phase, and is currently in the process of conducting the experimental reimbursement phase.

Unfortunately, although this study articulates very admirable objectives, the final outcome from this study will not be available and reported until 1978. It is my fear that this may indeed be too late to insure the continued viability of the physician extender concept.

I would submit that there is certainly a bit of dichotomy taking place when one agency in HEW has supported physician extender training and production to the tune of $30 million over the last 5 years, while another agency is denying reimbursement while it waits for data that will take 6 years to collect and report.

I personally feel that the physician extender concept, after 11 years of existence, has demonstrated that it is filling a need. Certainly the data is available to support this belief.

The Association of Physician's Assistant programs reports that there are now some 3,500 to 4,000 physician extenders working in practice settings and that 77 percent of these are in primary care disciplines. There are currently 1,500 to 2,000 graduates a year being produced by programs. These programs are accredited through a nationally recognized accreditation process and the majority of these graduates become certified as to their competence by a nationally accepted certifying examination.

Certainly it would seem we could provide these individuals with a mechanism to reimburse their employers for their services, as well as provide legislators, researchers, and educators the necessary data to analyze their potential cost saving to the health care system.

As a graduate physician's assistant, program director, and officer of the Association of Physician's Assistant programs, I have had ample time to discuss and think through the issues concerning the cost of service provided by the physician extender. Based on these thoughts, I would recommend that the committee consider the following as perhaps possible solutions to a number of very complex issues.

(1) That the SSA physician extender study be reexamined in order to determine if it can be completed sooner than 1978.

(2) That the Congress should consider the following reimbursement formula recently developed by the American Academy of Physician's Assistants in consultation with Mr. Jay Constantine, who is on the staff of the Senate Finance Committee.

This formula is considered noninflationary and would provide for services rendered by physician extenders. It is as follows: That each practice which cares for medicare patients determine what percent of the practice base this accounts for. This percent is then multiplied by a percentage of the physician's extender's annual salary—the percent caring for medicare patients. Then a percentage must be determined which accounts for that portion of the M.D.'s time supervising the physician extender's activities and the percent of practice overhead attributed to the medicare practice. These percentages are added and then multiplied to derive a cost figure which cannot exceed two times the physician extender's annual salary. These dollars could be paid to a practice in a 12-month interval at the beginning of each month.

The practice base percentages could be adjusted by 10 percent to incorporate seasonal flux and reassessed quarterly if the patient flux was greater than 10 percent of the base.

(3) That additional short-term evaluation studies should be considered that would examine more closely issues related to cost of training physician extenders; cost of employment of physician extenders in the practice setting; cost advantage or disadvantage of the physician extender to the patient/consumer and to the health care system.

With these final thoughts in mind, I would like to express my sincerest thanks to the committee for having had the opportunity to express my views to such a prestigious group.

I would like to, if I may, add one more piece of information for the record, a letter to the editor appeared in the Washington Post yesterday which speaks to the issue of reimbursement for physician assistants. I have copies if anyone would care for one.

[The prepared statement and attachment follow:]

STATEMENT OF JARRETT M. WISE, P.A.-C. DIRECTOR, PHYSICIAN'S ASSISTANT PROGRAM, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES, SECRETARY-TREASURER, ASSOCIATION OF PHYSICIAN'S ASSISTANT PROGRAMS

INTRODUCTION

The health care crisis in the United States has become, in the 1970's an accepted fact. A great part of the problem stems from a gradually increasing population with a rapidly increasing demand for health services, coupled with a disproportionate increase in, and maldistribution of, the services of physicians, dentists, nurses, and allied health personnel. This situation accentuates the crisis in the areas of great need—the inner city with its poverty and dense population and rural America where distance may compound poverty. The nature of health care delivery, in its extreme dependence upon technical procedures and personal services rendered by individuals, transforms much of the health care crisis into a manpower crisis, a trivalent problem involving numbers, utilization and distribution of personnel.

The inelastic supply of physicians has been further aggravated by the problem of maldistribution. Although on the average in the U.S., there is one physician for every 630 persons, in over one-third of the counties representing 8 percent of the nation's geographic area; there are no physicians at all, and the number of such counties is growing. In the inner cities, the maldistribution problem is chronic and appears to be getting worse.

In some parts of New York, the ratio is one physician for every 12,000 and Chicago's inner city has 1,700 fewer physicians than it did a decade ago.

The combined factors of the increased demand for health care linked with the maldistribution of health care providers has produced three serious adverse effects. These can be summarized as:

(1) Increased demand for health services over-taxes an already inelastic supply system and causes a severe back-up of already unavailable services.

(2) Healthy people must often be hospitalized for elective procedures in order to reap any benefit from their health insurance, and this in turn over-crowds health facilities and often acts as a barrier to entry by the sick.

(3) With the sudden increase in demands, instead of caring for the sick, doctors spend a large proportion of their time trying to find something wrong with well people, and they do this with techniques taught them to diagnose sickness. Searching for illness in well people is extremely irritating and frustrating to the physician, and extremely expensive for the taxpayer. To cater in part to this new and uncertain demand, there has been created over the last decade, a new innovative form of health manpower called the physician's assistant or physician's extender.

This testimony will review the development of the physician's extender profession, and examine issues of reimbursement for services rendered by physician's extenders.

It will conclude by offering recommendations that might be pursued to resolve some of the yet unanswered questions regarding the cost effectiveness of physician's extenders.

HISTORY OF THE PHYSICIAN EXTENDER CONCEPT

The American Medical Association (AMA) defines the physician extender as "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician, who is responsible for that assistant." This definition would certainly support a number of studies which have concluded that much of what a physician does during the

care and evaluation of his patients is routine, repetitious, and can be assumed by an education, well-trained physician extender.

Some of the benefits promised by the physician extender can be listed as follows:

(1) The physician extender can help the doctor deficit everywhere by expanding the amount and scope of services a physician can offer.

(2) The physician extender could be drawn from the names of a great number of qualified candidates who are turned away by M.D. programs for lack of space. Large numbers of nurses may seek to expand their skill through additional training to become physician extenders. Many thousands of trained ex-military corpsmen can translate their hard earned skills into useful civilian medical care functions as physician extenders.

(3) Because physician extenders can be trained in a relatively short period of time (2 years as compared to 8 to 13 years for the physician), not only can the spiraling costs of medical education be reduced, but the immediate need for primary care services can be met.

(4) Because the physician extender's salary is substantially less than that of a physician, in the long run his services will reduce or at least stabilize the cost of medical care to the patient.

(5) Because the physician extender is more accessible, patients may get better preventive care and may be able to get it sooner.

(6) By screening out the worried, well and asymptomatic patient who consumes an enormous amount of a physician's time and by relieving the physician's time and by relieving the physician of the burden of a number of routine duties, this allows the physician to reallocate his time to treating those patients who really need the expertise of the physician. In addition, this would allow the physician to keep abreast of new developments in medicine, help prevent work overload, and increase the physician's profession life span of service to the community. All of these factors could hopefully contribute, each in its own way, toward improving the quality of health care.

With all these potential benefits in mind, the Congress of the United States in 1971 enacted the Comprehensive Health Manpower Training Act, which has authorized approximately six million dollars annually to support colleges and univerisities with programs designed to train physician extenders.

As a consequence, the number of programs designed to educate and train physician extenders grew from six (6) in 1965 to sixty (60) in 1975. A result of this rapid growth was the formation of the American Academy of Physician's Assistants incorporated in 1968 and the establishment of the Association of Physician's Assistant Programs in early 1970. These Associations have assumed a leadership role in resolving a number of issues confronting this new profession. Among the early problems first resolved by these groups were issues of program accreditation and graduate certification.

ACCREDITATION OF PHYSICIAN EXTENDER PROGRAMS

The accreditation of physician extender training programs is currently being done by the American Medical Association, which accredits programs for training the "Assistant to the Primary Care Physician." The American Medical Association in cooperation with the American Academy of Family Physicians, and the Society of Internal Medicine formed a committee in early 1971 to prepare minimal standards for the conduct of educational programs preparing assistants to the primary care physician.

The committee, in the Fall of 1971, submitted to the governing bodies of their respective organizations draft standards which established criteria for the accreditation of programs training assistants to the primary care physician.

These standards for accreditation were unanimously approved by all the involved organizations, and in 1972, this same committee formed the "Joint Review Committee for the Assistant to the Primary Care Physician." This Joint Review Committee, upon recommendation from the Executive Board of each of the collaborating organizations, recognized a fifth organization in March, 1974, The American Academy of Physician's Assistants, which gave representation to products of physician extender programs.

These standards developed by the Joint Review Committee are known as the "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician." These "Essentials" are designed to access a program's

strengths and weaknesses in regard to administrative structure, curriculum, faculty and students.

The U.S. Office of Education has recognized the AMA accreditation mechanism and to date, more than 50 programs have been reviewed and have received varying degrees of approval (full approval, probationary approval, preliminary approval, provisional approval—New Program, non approval).

CERTIFICATION OF PHYSICIAN EXTENDERS

In response to the need for a national measure of competency, the National Board of Medical Examiners (NBME) accepted responsibility in April, 1972 for developing a national certifying examination for assistants to the primary care physician. Following the administration of the first examination by the NBME, in December, 1973. fourteen collaborating organizations formed the National Commission on Certification of Physician's Assistants (NCCPA). The National Commission is comprised of individuals from the following organizations: American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physician's Assistants, American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, American Nurses Association, American Society of Internal Medicine, Association of Physician Assistant Programs, Federation of State Medical Boards of the United States, National Board of Medical Examiners, and the United States Department of Defense. In order to maintain the high standards of the physician assistant profession, a re-registration and recertification process has been established by the National Commission.

State Legislatures and regulatory agencies have assumed responsibility in recognizing the physician extender and in regulating their practice. Over 37 states have enacted enabling legislation for physician extenders and, to date, no physician extender has been indicted nor convicted or professional negligence.

American medicine has therefore seen the establishment of a new profession with ongoing program accreditation, graduate certification, and the establishment of professional associations intent on maintaining the high standards of the profession.

EVALUATION OF PHYSICIAN EXTENDERS

Early in the 1970's, physician extender program educators and administrators articulated a number of areas which needed research to determine the future viability of the physician extender concept. Some of the areas of highest priority were:

(1) Quality of care delivered by physician extenders.

(2) The acceptability of physician extenders by patient, physicians, and other health professionals.

(3) The productivity of practices which employ physician extenders.

(4) Utilization of physician extenders in medically underserved areas.

(5) The cost influence of physician extenders on the patient, the practice and the health system.

A review of the literature on physician extenders is helpful in determining exactly what specific areas have been well researched in comparison to areas that have not been carefully evaluated. It appears that most of the literature tends to deal with the first four areas of concern. Very little research has been completed which speaks to the issue of the cost influence of physician extenders.

A brief summary of selected research in each of these broad areas is as follows:

QUALITY

In a study conducted by Dr. Henry Silver on the procedural quality of pediatric nurse associates, he found that of 280 conditions ranging from a well child to various degrees of illness, the physician and nurse associate were in agreement in 82% of cases; there was an insignificant difference in interpretation in 17% of cases, and there was a significant difference in interpretation in only 0.7% (2) of the cases. In one of the two situations, the nurse associate thought the child had an inflamed throat, and the physician diagnosed pneumonitis. In the other, the nurse also found an inflammed throat. Several hours later, the physician diagnosed meningitis, but the spinal fluid was entirely normal. Subsequently, the nurse was proved correct.

PHYSICIAN ACCEPTANCE

Various studies done over the past decade would lead one to believe that physicians not only accept the concept of physician extenders, but also that many physicians have utilized extenders on an informal basis for quite some time. Beasley's survey of physicians in the 32 counties of the eastern third of Kentucky showed that an average of sixty-eight (68) percent approved of trained assistants taking histories, doing parts of physical examinations, taking an active part in therapy, treating patients in the physician's absence using present protocol, and performing certain obstetrical procedures. He further showed that an average of thirty-one percent (31%) of residents had already delegated such tasks to an assistant.

Coyne and Harsen's survey of practicing physicians in Wisconsin showed sixty-one percent (61%) of respondents believed that assistants are needed and twelve percent (12%) stated that they would use them in their practice. In projecting this data, the authors estimated that approximately 2,000 physicians would employ doctor's assistants.

Wise and Piemme, in a survey of some 1,500 physicians located in the Washington Metropolitan Area, showed eighty-three percent (83%) of respondents believed physician extenders were needed and fifty-two percent (52%) stated that they would use them in their practice. These authors raised an interesting point in discussing their surveys—it was done in 1971 prior to the initiation of their own training program. They plan to repeat this survey after they have graduated their second class of students to see if the employment of their physician extenders has correlated with the needed projections based on their survey.

PATIENT ACCEPTANCE

Several studies have shown not only do patients accept care from physician extenders, but also that some patients prefer care provided by the combination of the physician and the physician extender.

Silver and Lewis showed that in a private practice which served middle class patients and employed a Colorado-trained Pediatric Nurse Associate, ninety-four percent (94%) of the parents expressed satisfaction with services of the Pediatric Nurse Associate-Physician combination, and fifty-seven (57) percent stated that the joint care was better than that of the pediatrician alone.

Parents were particularly satisfied with the home visits which the nurse associate made. Over ninety (90) percent considered the physician-nurse associate combination to be the most desireable form of care.

Pondly, et al, in a survey done in 1970 on the patient acceptance of the physician assistant, used 72 patients from practices who employed a Duke-trained physician assistant in their pratcice. One practice setting had mostly public patients, two had mostly private patients, and one was a community general practice clinic. The researchers found a strongly positive correlation between acceptance and the number of years of formal education. Acceptance was curvilinearly related to income. It was greatest for the middle income ranges and less for the lower and higher income patients.

In a more recent study done on patient acceptance by Nelson, Jacobs and Johnson in 1974, 900 patients in 18 practice settings using MEDEX graduates were poled. They found that eighty-nine (89) percent of respondents rated the MEDEX high in terms of technical competence, eighty-six (86) percent rated them high in terms of professional manner, seventy-one (71) percent reported improvement in the quality of care, and seventy-nine (79) percent reported they felt the access to care had improved since the MEDEX joined the practice.

ACCEPTANCE BY OTHER HEALTH PROFESSIONALS

For a system of health delivery to function efficiently, there must be a working level of cooperation between the traditional workers within the system and the physician extender who is relatively new to most health care delivery systems.

Not nearly as much hard data has been generated in regards to acceptance by other health workers, although a study by Breyspraak and Pondly in 1969 measured the role relations of physician's assistants in a hospital. Their findings suggested that self-acceptance and satisfaction was greatest when the assistant was functioning as an "assistant to the physician" carrying out unique functions dis-

tinct from those of other paramedical personnel and congruent with the ideals of his training. They further concluded that acceptance by other allied health workers was likely to be higher if the assistant performed a set of tasks that visibly helped them in their own work. An example is the assistant serving as a liaison for the physician, communicating information about a patient's care or performing laboratory analysis. In short, other health workers were more accepting when they understood the assistant's role and saw how it helped them in the performance of their own duties.

PRODUCTIVITY

Measurement of practice productivity has been looked at by a number of researchers. Probably the most detailed study was done by Smith, Miller and Golladay in 1972, which employed an activity analysis model and collected data from 14 practices using physician assistants. Their results suggested that physician assistants could increase the productivity of private medical practices from 40%—74% depending on the specific delegations.

UTILIZATION

In October, 1974, the Association of Physician's Assistant Programs conducted a survey of over 1,300 practicing physician extenders. The survey revealed seventy-seven (77) percent of respondents are practicing in primary care disciplines. In addition, forty-five (45) percent of graduates are employed in practice settings within communities of populations less than 20,000. The results of this survey documents that physician extenders are practicing in primary care disciplines in small rural communities.

COST INFLUENCE OF PHYSICIAN EXTENDERS

As noted earlier, very little data has been collected which speaks to the cost influence of physician extenders on patients, physician practice and the health system.

The only recent study available which has dealt with cost was done by Nelson, Jacobs, Corder and Johnson in the Fall of 1975. This study looked at revenues generated and expenses incurred by twelve (12) physician assistants (MEDEX) who had salaried positions for at least one year. Its focus was to determine their financial impact on their employer's primary care practices. They found that ten (10) out of twelve (12) practices experienced substantial financial gains of estimated revenue over expenses ascribed to the activities of the physician's assistant (MEDEX).

The only other major study to the best of my knowledge that is being conducted which deals with the cost issues of physician extenders, is the Social Security Administration study in reimbursement of physician extenders under Medicare, Part B.

This study is of such critical importance that it will be discussed in detail in the following text.

THE SSA PHYSICIAN EXTENDER REIMBURSEMENT STUDY

Under Congressional authority provided in the Social Security Amendments of 1972 (H.R. 1, P.L. 92-603, Section 222), the Social Security Administration has been conducting a nationwide study designed to address issues concerning how physician extender utilization can decrease the cost of medical care and increase the access to primary care medical services.

This study has been referred to as the Physician Extender Reimbursement Study, and plans to make Medicare, Part B reimbursement, available on an experimental basis to participating non-institutional primary care practices for services provided by physician extenders to medicare beneficiaries.

The study was awarded to a private contractor in December of 1973. The first part of this award directed the contractor to conduct a literature search and plan a study design for implementation under the second half of the contract.

The study now consists of two phases: the baseline data collection activity and the reimbursement experiment. The contractor and the Social Security Administration, with the complete cooperation of the Association of Physician's Assistant Programs and the American Academy of Physician's Assistants has, to the best of my knowledge, completed the baseline data collection phase, and is currently in the process of conducting the experimental reimbursement phase.

Unfortunately, although this study articulates very admirable objectives, the

final outcome from this study will not be available and reported until 1978. It is my fear that this may indeed be too late to insure the continued viability of the physician extender concept.

SUMMARY

I would submit that there is certainly a bit of a dichotomy taking place when one agency in H.E.W. has supported physician extender training and production to the tune of 30 million dollars over the last five years, while another agency is denying reimbursement while it waits for data that will take six years to collect and report.

I personally feel that the physician extender concept, after 11 years of existence, has demonstrated that it is filling a need. Certainly the data is available to support this belief.

The Association of Physician's Assistant Programs reports that there are now some 3,500 to 4,000 physician extenders working in practice settings and that seventy-seven (77) percent of these are in primary care disciplines. There are currently 1,500–2,000 graduates a year being produced by programs. These programs are accredited through a nationally recognized accreditation process and the majority of these graduates become certified as to their competence by a nationally accepted certifying examination.

Certainly it would seem we could provide these individuals with a mechanism to reimburse their employers for their services, as well as provide legislators, researchers and educators the necessary data to analyze their potential cost saving to the health care system.

RECOMMENDATIONS

As a graduate physician's assistant, Program Director, and Officer of the Association of Physician's Assistant Programs, I have had ample time to discuss and think through the issues concerning the cost of service provided by the physician extender. Based on these thoughts, I would recommend that the committee consider the following as perhaps possible solutions to a number of very complex issues.

(1) That the S.S.A. physician extender study be re-examined in order to determine if it can be completed sooner than 1978.

(2) That the Congress should consider the following reimbursement formula recently developed by the American Academy of Physician's Assistants in consultation with Mr. Jay Constantine, who is on the staff of the Senate Finance Committee. This formula is considered non-inflationary and would provide for services rendered by physician extenders. It is as follows: that each practice which cares for Medicare patients determine what percent of the practice base this accounts for. This percent is then multiplied by a percentage of the physician's extender's annual salary (the percent caring for medicare patients). Then a percentage must be determined which accounts for that portion of the M.D.'s time spent supervising the physician extender's activities and the percent of practice overload attributed to the Medicare practice. These percentages are added and then multiplied to derive a cost figure which cannot exceed two times the physician extender's annual salary. These dollars could be paid to a practice in a 12-month interval at the beginning of each month.

The practice base percentages could be adjusted by 10% to incorporate seasonal flux and reassessed quarterly if the patient flux was greater than 10% of the base.

(3) That additional short term evaluation studies should be considered that would examine more closely, issues related to the: cost of training physician extender; cost of employment of physician extenders in the practice setting; and cost advantage or disadvantage of the physician extender to the patient/consumer and to the health care system.

With these final thoughts in mind, I would like to express my sincerest thanks to the Committee for having had the opportunity to express my views to such a prestigious group.

[Letters to the Editor, Washington Post, May 16, 1976]

THE MALDISTRIBUTION OF HEALTH CARE

Your editorial of April 24 entitled "Rural Health Care in Appalachia" correctly reflects one facet of the issue of reimbursement for the services of physician's assistants and nurse practitioners under Medicare and Medicaid. A

major premise of the "physician extender" concept at the time of its inception ten years ago was the hope that these mid-level practitioners would distribute themselves in such a way as to help redress the geographic maldistribution of health care. Indeed, the evidence is that they have done so.

A survey by the Association of Physician Assistant Programs of the 2,500 graduates of all federally funded programs through 1974 revealed that 45 per cent of graduates are employed in practice settings within communities of populations less than 20,000. Only 21 per cent were employed by practices in urban communities of populations greater than 100,000. Yet the concept is threatened by the failure of federally funded health programs to provide reimbursement to the employing physicians for the care rendered by these new health practitioners. This is not only a threat to the Appalachian Regional Commission, but to National Health Service Corps and Office of Economic Opportunity funded programs as well. In all of these situations federal support is term-limited with the intent that the practice ultimately sustains itself with patient income. There is clear evidence that physician's assistants can extend the scope of practice of the physician with a real potential to contain the cost of care in rural and inner-city settings. In recognition of this information, more than 39 state medical practice acts have been altered to permit delegation of health care responsibility to the physician's assistant.

The ultimate irony is that the Bureau of Health Manpower has expended more than $15 million dollars each year since 1872 to train physician's assistants and nurse practitioners, while Medicare and Medicaid programs continue to deny reimbursement for the care they deliver. At least six of the 50 PA training programs have or will cease operation within the year, in no small part because of anxiety regarding employability of graduates, which is in turn related to the reimbursement issue.

Clearly, resolution must be sought for this dilemma.

KARL R. KATTERJOHN JR.,
Associate Director,
Physician's Assistant Program.

THOMAS E. PIEMME, M.D.,
Chairman, Department of Health Care Sciences,
George Washington University.

Mr. WISE. This article very nicely summarizes what my entire testimony has discussed.

Mr. VANDER VEEN. I appreciate that, and may I see the additional material. I would like to see a copy of it if I may.

It has just been suggested to me that it would be a good idea if we adjourn for a brief moment and walk over to the full committee. I had no idea that there would be this kind of interest in the subject. I and my fellow members on the subcommittee staff are intensely interested, and obviously a good many others are, too.

So, we will adjourn this hearing for about 7 minutes, the length of time it takes for us to walk from here to the full committee room.

[Brief recess.]

Mr. VANDER VEEN. We will resume where we were. I am appreciative of you all making that transfer.

Mr. Wise, you had completed your testimony. I was about to ask you a few things about physician's assistants.

First, if you do not mind, could you tell me, please, what presently is the average salary of a physician's assistant on a yearly basis.

Mr. WISE. The average salary of a physician's assistant is indeed calculated on the reasons for which or the practice-setting that the physician's assistant practices in. Based on a national study done about a year ago, the average salary now is at $14,500 per year.

Mr. VANDER VEEN. If you know, what is the average annual salary of an M.D. in this country or the average annual income of an M.D.?

Mr. WISE. I would certainly have to guess at that figure. I would think it would depend also on the practice-setting whether he was working in an academic medical center or private practice. I would guess $35,000 or $40,000 possibly.

Mr. VANDER VEEN. Going back to your prepared statement, at one point you made reference to the fact that one of the agencies of HEW has supported physician extender training and production to the tune of $30 million a year, to quote you, "over the last 5 years; while another agency"—of HEW, I presume you mean—"is denying reimbursement."

Would you identify those agencies, please?

Mr. WISE. Yes, sir. The Health Manpower Act of 1971 allowed for the establishment of training programs to train physician extenders. That has been administrated since 1971 through the Bureau of Health Manpower, which was of the National Institutes of Health, and is currently being done through the regional offices of the Bureau of Health Manpower.

The agency which is currently looking at reimbursement—and I want my point to be not misunderstood—that is, through the Social Security Administration study, is determining a reimbursement formula. I think it is critical, and it bothers me that it is going to take till 1978 before we see some data from this study. Since, indeed, we have physician's assistants in the field now, I think the data demonstrates that. They are being accepted by patients and by physicians, and they are going out into primary care practices.

But I am not sure this is going to last long if physicians cannot cover the costs of the salary of a physician's assistant, if he cannot be reimbursed for the employment cost.

Mr. VANDER VEEN. How are physician extenders usually paid?

Mr. WISE. They are paid on a straight salary per year.

Mr. VANDER VEEN. By whom?

Mr. WISE. By the physician they work for, the employing physician.

Mr. VANDER VEEN. Are not physician extenders most often used to increase patient load, would you say?

Mr. WISE. They can, indeed, increase patient load or practice productivity, or they can certainly be used in underserved areas as extensions of the physician, so long as it is accepted through State law and also that there is a method of supervision written into that equation.

Mr. VANDER VEEN. You say, on the one hand, it seems to me, that while you have a great many new people entering the physician extender field—that is 1,500 to 2,000 I think is the figure referred to—as a profession, on the other hand you say that the continued viability of the physician extender as a profession is in question.

It seems to be contradictory. Would you mind explaining that?

Mr. WISE. It would certainly seem so. As I noted, the Bureau of Health Manpower Education invested money in training individuals based on data and assumptions that we could expand the services that a physician could render by utilizing well trained physician's assistants.

Certainly, programs are flourishing and have been for the past 5 years, and are turning out a good number of these individuals into the health care system.

But their utilization is tied to the fact whether a supervisory system an be determined and used by a physician to employ one of these individuals. Certainly, I think he would employ them, but if a part of his practice was medicare and medicaid patients, and he used the physician's assistant to do some of the functions or perform some of the patient-related procedures for him on that patient population, for example, and could not get paid for these services, then he would have to use the physician's assistant exclusively in another part of the practice for seeing patients who were non-medicare or he could not obtain third-party payment. I think third-party payment under the blues, as well, is hinged upon it also and will follow very closely reimbursement under medicare, as would medicaid.

If I were a physician and not a physician's assistant and hired a physician's assistant, I would like to be able to say part of his salary or most of it or whatever was covered by the income from patient services or the income from third-part payers.

In fact, at this point it is not. I think it is a matter of time before the viability of the concept becomes very shaky, to say the least, because physicians are not going to hire physician's assistants if they cannot get the services, which the physician's assistant provides, paid for.

Mr. VANDER VEEN. One final thing, Mr. Wise. Do physician's assistants make a greater contribution to practice productivity when working independently of physicians or when they are working under the close supervision of physicians?

Mr. WISE. Again, that is a question that has been looked at, but certainly could be looked at more. I think it has been determined pretty well that the increased practice productivity in a practice working with a physician under fairly close supervision is anywhere from 30 to 50 percent.

As far as independently, I would say that those experiments are in process now. An example would be where physician extenders are used in West Virginia, in neighborhood health centers where they are the patient care deliverers and their supervision is carried out by telephone or other methods of communication, as well as having a physician circuit ride on a once every 3 or 4 days' basis seeing patients the physician extender cannot handle. So, certainly we are taking a physician extender in one instance and increasing productivity.

In the other instance we are taking a physician extender and using him in the physician's place because a community of, say, 5,000 or 8,000 could not support the salary of a physician.

Mr. VANDER VEEN. Thank you.

I appreciate and the subcommittee appreciates very much, Mr. Wise, your contribution here today. Let me thank you again for appearing.

Our next witness is Dr. Carole Steinbock.

Dr. Steinbock, would you take a place at the witness table where you can use one of the microphones?

Dr. STEINBOCK. Thank you very much.

Mr. VANDER VEEN. Would you identify yourself and what your recommendations have been. I think I would have to give you the same admonishment that I have given other witnesses as they have appeared. We are trying to cover a lot of ground in a fairly short time. Please proceed.

STATEMENT OF CAROLE STEINBOCK, M.D., ASSISTANT PROFESSOR AT THE ALBERT EINSTEIN COLLEGE OF MEDICINE AND DIRECTOR OF THE CENTER FOR SOCIAL RESEARCH IN REHABILITATION MEDICINE; ACCOMPANIED BY ANN CORRIGAN, PROGRAM COORDINATOR, THE DAY HOSPITAL SERVICE

Dr. STEINBOCK. I appreciate that, Mr. Chairman. Let me say we appreciate the opportunity to come here and tell you about the history of the Day Hospital project.

My name is Dr. Carole Steinbock. I am an assistant professor at the Albert Einstein College of Medicine and director of the center for social research in rehabilitation medicine. I am research director for the evaluation of the Day Hospital Service in rehabilitation medicine. With me is Miss Ann Corrigan, who is program coordinator for the Day Hospital Service.

In June 1974, the National Center for Health Services Research of the Department of Health, Education and Welfare awarded a grant to the Albert Einstein College of Medicine in the Bronx, N.Y., for the purpose of evaluating a Day Hospital Service in Rehabilitation Medicine. This grant was to extend for a period of 3 years, from July 1974 through June 1977. The Day Hospital Service was to have been established at the Bronx Municipal Hospital Center, a municipal facility of the New York City Health and Hospitals Corp., in order to provide intensive rehabilitation service to severely disabled patients who were to live at home and come to the hospital daily for treatment.

Intensive rehabilitation treatment generally consists of a range of services, such as physical, occupational and speech therapy, phychological and vocational counseling, and social work, designed to enable the patient to recover as much of his or her capacity for self care and mobility as possible. Traditionally this type of medical care has been offered on an inpatient basis, making it a very expensive service to provide. By allowing patients to live at home while receiving this treatment, it is possible that it will be more effective and less costly. The grant awarded to the Albert Einstein College of Medicine was intended to permit the evaluation of these potential benefits. It is now almost 2 years later. Due to the inability of Federal staff to devise a mechanism that would transmit funds authorized under legislation, Public Law 92–603 section 222, to the New York City Health and Hospitals Corporation for Day Hospital Service, this program has still not been implemented.

The Day Hospital was to serve both medicare and medicaid patients. Reimbursement for medicare patients initially was to have come directly from the Social Security Administration. The Albert Einstein College of Medicine was informed on May 16, 1974, by the Director of the Division of Special Operations of the Bureau of Health Insurance, that the Bureau of Health Insurance would provide reimbursement to the New York City Health and Hospitals Corp. for all costs of treatment of medicare patients in the Day Hospital. The New York State Department of Social Service, the single State agency responsible for medicaid, had agreed to participate by reimbursing the New York City Health and Hospitals Corp. at an outpatient rate for services provided to medicaid patients in the program. This was

to be supplemented by "medicaid deficit" funding contained in the grant awarded to the Albert Einstein College of Medicine and was needed because the cost of care, although expected to be significantly less than inpatient care, was expected to cost more than routine outpatient care.

A meeting was held in the fall of 1974 and was attended by representatives of the Albert Einstein College of Medicine, Bronx Municipal Hospital Center, New York City Health and Hospitals Corp., Social Security Administration, National Center for Health Services Research and the New York State Department of Social Service. The details for reimbursement procedures were finalized, subject only to an exchange of correspondence between the New York City Health and Hospitals Corp. and the Social Security Administration. This exchange was completed in December 1974. In anticipation of a January 1 starting date, steps were taken to recruit and hire staff.

During January and February we attempted to find out when the Social Security Administration would give final approval for the program to start. In late February, the program staff was finally informed that the responsibility for authorizing medicare reimbursement had been transferred from the Division of Special Operations to the Office of Research and Statistics. The Office of Research and Statistics was unable to indicate either what was causing the delay or when authorization would be given. At that time, an attempt was made to implement the medicaid portion of the program. This attempt was thwarted when the New York State Department of Social Service informed the program staff that it would not participate in the Day Hospital Service until the issue of medicare participation was resolved.

Concern over the seemingly endless delays prompted us to request a meeting with representatives of the National Center for Health Services Research and the Social Security Administration. In May of 1975, a meeting was held in Rockville with representatives of the Office of the Assistant Secretary for Health, National Center for Health Services Aesearch, Social Security Administration, Social Rehabilitation Service, Bronx Municipal Hospital Center and Albert Einstein College of Medicine. We were told at that time that a major modification had been made concerning the funding and were advised of the following: (1) the medicare portion of the Day Hospital Service was to be funded as a section 222 project under Public Law 92–603; (2) the National Center for Health Services Research would enter into an agreement with the New York City Health and Hospitals Corp. to fund the medicare portion of the project, with funds to be provided to the New York City Health and Hospitals Corp. by the Social Security Administration upon authorization by the National Center for Health Services Research; (3) a series of waivers would be needed and sought by the Federal staff for both medicare and medicaid recipients.

At that meeting we were assured by representatives of the National Center for Health Services Research and the Office of the Assistant Secretary of Health that within 10 weeks the Government would complete all steps required to enter into an agreement so that the program could be implemented on September 1, 1975. We were told that (1) by June 1, 1975, an agreement would be forwarded that would permit re-

imbursement to the New York City Health and Hospitals Corporation, (2) that by July 1, 1975, the Division of Direct Reimbursement would prepare a reimbursement protocol for medicare billing and that (3) by July 15, 1975 the Office of the Assistant Secretary for Health would obtain the necessary medicare waivers.

We were also informed that the evaluation of the Day Hospital Services was to be part of a larger National Center for Health Services Research sponsored study of alternatives to nursing home care. We were told that reimbursement for the Day Hospital Service would be contingent upon our agreement to provide data that could be used in conjunction with these long term care experiments.

At meetings on July 22 and 25, 1975, representatives of the National Center for Health Services Research, Division of Direct Reimbursement/Social Security Administration, Albert Einstein College of Medicine, Bronx Municipal Hospital Center, and National Center for Health Services Research met to discuss program implementation. Agreement was reached on 95 percent of the data to be provided to the National Center for Health Services Research for use with the long-term care experiments. We were advised at these meetings that the funding plan outlined to us in May had been abandoned. The National Center for Health Services Research was going to request that the Albert Einstein College of Medicine respond to a request for a proposal for the agreed upon data. The resulting contract was to be the vehicle for the reimbursement for services. We were assured that the contract mechanism could be worked out within a few weeks.

On August 18, 1975, we received a first working draft of a request for proposal that would require us to submit a proposal to do research for which we already had an operating grant. It was apparent that the program was not about to be implemented and a meeting with the Director of the National Center for Health Services Research was requested by the principal investigator. In that meeting, and in a follow up letter, the Albert Einstein College of Medicine was assured that "slippage directly related to the organizational logistics will not jeopardize support to completion."

A request for proposal was sent to us on October 31, 1975. This request for proposal called for the Albert Einstein College of Medicine to be responsible for the delivery of the services required for the day hospital service at the Bronx Municipal Hospital Center. The National Center for Health Services Research was immediately advised that, because of contractual relationships between the New York City Health and Hospitals Corp. and the Albert Einstein College of Medicine, that this was not possible.

We suggested that the National Center for Health Services Research convene a meeting with the Albert Einstein College of Medicine and the New York City Health and Hospitals Corp. to determine how a contract(s) could be written to implement the program and provide the data. On November 11, 1975, the National Center for Health Services Research rescinded the request for proposal. We were told that a revised request for proposal would not be forthcoming until we had submitted a revised detailed evaluation proposal. This was submitted 1 month later, on December 10, 1975. Again, greatly concerned about the delays we wrote to the Assistant Secretary for Health to ask his

assistance in expediting the program implementation. We have had no response.

On January 8 and 9, 1976, we met with representatives of the Division of Direct Reimbursement/Social Security Administration and the National Center for Health Services Research and again advised them of a need to find a workable funding mechanism. They agreed to investigate the feasibility of a separate contract between the Department of Health, Education, and Welfare and the New York City Health and Hospitals Corp. for reimbursement for services for medicare patients. We were informed on January 27 that the National Center for Health Services Research had decided not to pursue this mechanism.

On January 21, 1976, an official request for proposal was issued that required the Albert Einstein College of Medicine to be responsible for services at the Bronx Municipal Hospital Center and for the provision of data. We responded as we had earlier, that the Albert Einstein College of Medicine could provide the data but could not be responsible for the provision of service. A complete response to the request for proposal was submitted on February 24, 1976. This response included a suggestion that the Government contract for services directly with the New York City Health and Hospitals Corp., the certified medicare provider.

A meeting was held on March 25, 1976 with representatives of the National Center for Health Services Research, Division of Direct Reimbursement/Social Security Administration, New York City Health and Hospitals Corp., Bronx Municipal Hospital Center and Albert Einstein College of Medicine to discuss the details of the reimbursement protocol that had been prepared by the Division of Direct Reimbursement/Social Security Administration. After agreement was reached on the protocol, the problem of finding a reimbursement mechanism was addressed.

Two alternate mechanisms were proposed, both of which were acceptable to the Albert Einstein College of Medicine and the New York City Health and Hospitals Corp.

In a conversation with a Health Resources Administration contracts officer 10 days later, we were told that no further work could be done until alternatives were proposed in writing. These alternatives were proposed in an April 19, 1976, letter from the Albert Einstein College of Medicine to the Health Resources Administration contracts office. On April 30, 1976, the continuation application for the grant to evaluate the day hospital service was submitted. If the day hospital were to become operational in July, we would be starting the third year of the grant.

Last week, the Director of the National Center for Health Services Research suggested that we meet to determine whether a funding mechanism can be worked out. We have requested that the meeting be attended by individuals with the authority to decide upon and approve a funding mechanism. We have unofficially been informed that some Federal staff now feel that, given the complexities surrounding this project, it is impossible to work out a way to transmit funds from the Federal Government to the New York City Health and Hospitals Corp. for the day hospital service.

I would like to point out that the cost of treatment for the day hospital service is expected to be a maximum of $120 a day as opposed

to the $200 a day the care now costs for these patients. In addition, it is likely that the cost of care would be less because the number of days of treatment would be less. There would be no weekend or evening treatment.

It is our belief that if Congress has directed Federal agencies to develop such programs, and the day hospital is a desirable program, that a funding mechanism can be worked out.

That concludes my statement. Ms. Corrigan and I would be happy to answer any questions that you have for us.

Mr. VANDER VEEN. Thank you very much for your statement.

Rather than direct a question to you immediately, since we have Mr. Cardwell here, I would like to ask you, Commissioner—and I apologize for not suggesting that I was going to do this earlier—can you make a response to the statement that was just put into the record by Dr. Steinbock?

Commissioner CARDWELL. Well, which aspect of the statement, Mr. Chairman?

Mr. VANDER VEEN. A general reaction to the entire statement. This was a narrative of an effort extending over a period of years to work out some kind of a funding mechanism for what seems to be an idea that would come within the terms of the sections granting funds to HEW to find ways to save money.

Commissioner CARDWELL. Well, I admire her perseverance and her patience. I would say at least that, but I cannot speak to the details of the project.

It is very possible that, if I were to examine it, I might find that there are problems in the original arrangement of her project as well as problems within HEW.

I have been told about the project. As it has been described to me, the issue within the Social Security Administration on the project has centered on the question of who would play the role of evaluator of the end result, whether it would or should be Einstein College of Medicine or whether it should be some third party.

I gather from her description that there have been substantive concerns about the project on the part of the Health Resources Administration. If that is correct, I think they are the ones who should speak to it.

Our role in this project would be twofold. First, to decide whether a waiver should be appropriately granted from the existing statutory requirement that would not permit reimbursement in other words, we would have to make a deliberate document of a waiver to that effect.

Our second role would be that once a project was consummated by the Health Resources Administration, it would be our job to arrange for a payment system between the Social Security Administration, Bureau of Health Insurance, and the administrator of the project and/or the actual provider of the services.

I think from her description there may have been some doubts in the minds of various persons in HEW as to who was going to play what role at their end of the project. But I am just guessing from her description. I am not familiar with the details of the project, beyond the description I just gave you.

Mr. VANDER VEEN. Is there anyone here, Commissioner, who would be able to comment further on this statement?

Commissioner CARDWELL. I think Dr. Cooper and his staff would be better prepared to speak to that than would we.

Dr. COOPER. We have the Director of the Center for National Health Services Research here. He could speak to the recent history of the project.

Mr. VANDER VEEN. Fine. I would appreciate it very much if he would respond. Identify yourself.

Dr. ROSENTHAL. I am Director of the National Center for Health Services Research.

There probably is not any uncomplicated answer to what has obviously been a very, very complicated set of relationships which go back for the Center with this project to I think 1972 when it was originally proposed as a grant that arrived through the normal grant processes originally in a setting different, I think, from the current setting—the providing institution. I mean not from Albert Einstein, but the hospital.

Dr. STEINBOCK. No; the setting has not changed.

Dr. ROSENTHAL. At any rate, the project was of interest to the National Center because the project provided us with an opportunity to stimulate an evaluation of an alternative method of service delivery in a long-term carrier area, a matter with which we had a long history of interest and which was of more immediate congressional interest as well. It took about a year or two before the project could be assessed, evaluated, and recommended for funding.

But the understanding on the part of the National Center for Health Services Research at the time was that the grand award was based on our part by a positive assessment of the proposals of the project and/or commitment to the issue that it was addressing and our belief in the competency of the researchers who were undertaking the research. The assumption was made that the mechanics related to reimbursement services required to operate the demonstration could be negotiated, I suppose.

In retrospect, I believe that that was more naive on the part of all the parties concerned than it proved to be.

[The following detailed testimony was submitted by Dr. Rosenthal and is inserted for the record. Dr. Steinbock, of the Albert Einstein College of Medicine, did not have the opportunity to respond to it.]

I am Director of the National Center for Health Services Research, Health Resources Administration, Public Health Service.

There is no simple way to answer the particular question raised here. The project at the Albert Einstein College of Medicine has involved a very complicated set of relationships. The project is based on a demonstration that has at one time or another required negotiations with the New York City Health and Hospitals Corporation, the Albert Einstein College of Medicine, Jacobi Hospital, the Social Rehabilitation Service, the Social Security Administration, the Health Resources Administration and the New York State Department of Social Services.

The National Center for Health Services Research initially became involved in this project as the result of a grant proposal submitted in 1972. A similar proposal was at the same time submitted to the Social Security Administration. Because the Social Security Administration insisted that the demonstration be evaluated by a party other than the research group at the Albert Einstein College of Medicine, the grantee preferred to receive support for the project from the National Center for Health Services Research. However, the support from the National Center only involved funding for the analysis. Reimbursement for services provided in conjunction with the demonstration was necessarily to be the responsibility of the Social Security Administration and the Social Rehabilitation Service. Because of a number of administrative difficulties including the resignation of the Principal Investigator at the Albert Einstein College of Medicine, the original proposal was never funded.

The project proposed by the Albert Einstein College of Medicine was of interest to the National Center because it provided us with an opportunity to study an alternative method of service delivery in the long-term care area—a research issue which has been of interest to the National Center for several years and which has attracted the attention of the Congress as well. Because of continuing concern with this problem, the National Center for Health Services Research agreed to provide support for the study when a new research proposal was submitted by the grantee in 1974. A grant award was made in June of that year. That award was based on our positive assessment of the proposal, our commitment to the issue that was being addressed, and our belief in the competency of the researchers who were to undertake the study. Under the terms of the grant the National Center agreed to support the evaluation of a demonstration. However, the National Center was not in a position to subsidize the services of the Medicare and Medicaid eligibles who were to be part of the demonstration. Moreover, the grant award from the National Center was made on the assumption that the problems associated with reimbursement for services provided in a day hospital situation could be negotiated with the Social Security Administration and the Social and Rehabilitation Service with relative ease.

Because of the need for waivers to permit reimbursement under Section 222 of the Social Security Act, the problems associated with defining the services that would be paid for, and the difficulties of dealing with different State and municipal agencies which would have to be involved in either the provision of services or in arrangements for reimbursements, the assumption by all the parties concerned that it would relatively be easy to implement the demonstration proved to be naive.

Mr. VANDER VEEN. May I interrupt you, Doctor.

Dr. ROSENTHAL. Yes, sir.

Mr. VANDER VEEN. I ask you this. What was the general feeling toward the concept of the day hospital service? Was it looked upon favorably?

Dr. ROSENTHAL. Well, the hospital clearly was looked upon at least as favorably enough to desire to fund the project that was designed to take a closer look at that.

Mr. VANDER VEEN. There was a decision at one point to fund the project, was there not?

Dr. ROSENTHAL. To fund the research components of the project.

Mr. VANDER VEEN. All right. And that decision was reversed.

Dr. ROSENTHAL. That decision has not been reversed. At the current time, that project is being funded and receiving research funds, most of which are not really spent because the demonstration that most of their energies would be devoted to assessing has not been initiated.

Mr. VANDER VEEN. Would you care to respond to that, Dr. Steinbock?

Dr. STEINBOCK. Yes. It is a sort of complicated issue, as we all realize.

Mr. VANDER VEEN. Is what he said true?

Dr. STEINBOCK. Yes. In 1974——

Mr. VANDER VEEN. Why have you not received funds at your particular center?

Dr. STEINBOCK. We have received and are operating now out of a research grant from the National Center. That research grant was given to the Albert Einstein College of Medicine for the purpose of evaluating the day hospital. The program itself has never become operational.

Mr. VANDER VEEN. Why not?

Dr. STEINBOCK. I can only say that until February 1975 it appeared that there was no problem in reimbursing for services. There were some delays that were just due to the fact that people were taking a long time to get things done.

The real confusion began when the responsibility for reimbursement of services was transferred from one part of the Social Security Administration to another part of the Social Security Administration. I cannot say what was behind that, but from our point of view that is when the mechanism that had originally been agreed upon—to reimburse for the services—broke down. In other words, at the time that grant was awarded, there was a method for reimbursing for services. It seems that after the identification of this project as a section 222 project, it became impossible to find a mechanism to reimburse for its services.

Mr. VANDER VEEN. Dr. Rosenthal, if I can return to you, without infringing on the rights of the other witnesses who are here and have taken the time to be here, I would like to pursue this briefly.

The project which Dr. Steinbock describes was funded for evaluation. Am I correct?

Dr. ROSENTHAL. The project was funded for the development of a research design and for evaluation of that particular day care experiment. The dimensions of that evaluation were part of the original grant proposal.

Mr. VANDER VEEN. But it has not been funded for operational purposes?

Dr. ROSENTHAL. For reimbursing for providing the services, correct.

Mr. VANDER VEEN. Are there any projects anywhere else in the country which have been funded operationally?

Dr. ROSENTHAL. I do not know of a day care demonstration such as this one which has been funded in an operational stage. We do have six other demonstrations that involve aspects of day care, as well as homemaker services. Those have been funded and have received waivers and have now completed the process of admitting patients into the demonstration program.

Mr. VANDER VEEN. Is your testimony that there is no effort, no project like the one that was described by Dr. Steinbock, being funded anywhere in the country?

Dr. ROSENTHAL. We are funding in our section 222 demonstrations a day care demonstration.

Mr. VANDER VEEN. Where is that?

Dr. ROSENTHAL. In White Plains, N.Y. That is similar, but not identical. So an honest answer to your question is that so far all the demonstrations are unique because there are only a very few of them.

Mr. VANDER VEEN. Is the one in White Plains a day hospital project?

Dr. ROSENTHAL. I do not think so.

Dr. STEINBOCK. I believe that ours is the only day hospital project. All of the other day care projects draw their patients from those who have completed a term of hospitalization and may or may not require nursing home care. These programs are basically alternatives to nursing home or long-term care.

The day hospital project is an alternative to inpatient hospitalization. The patients in this program would be people who have been in the hospital because of an amputation or a stroke but who are going to stay in the hospital for further rehabilitation. They would not be going to a nursing home until after completion of rehabilitation treatment.

Mr. VANDER VEEN. All right. Because of the number of witnesses we have and the ground that we have yet to cover, we are going to move on at this point.

I am going to ask some of the other people who are going to testify on something else about this particular project. Do you have anything to add, Dr. Steinbock, before you complete your testimony at this point?

Dr. STEINBOCK. Do you have anything, Ann?

Ms. CORRIGAN. No.

Dr. STEINBOCK. No. I just thank you for the opportunity of discussing this. We are still hopeful and we are still optimistic.

Mr. VANDER VEEN. You are very welcome for the opportunity.

The chairman of the subcommittee is here. Mr. Vanik, do you care to ask questions?

Mr. VANIK. I have no questions. I am following very carefully the transcript.

Mr. VANDER VEEN. Thank you very much, Dr. Steinbock.

Dr. STEINBOCK. Thank you.

Mr. VANDER VEEN. Commissioner Cardwell, would it be best if you testified at this point. in view of the different times of arrival? Or what would be the best sequence?

Commissioner CARDWELL. I think our preference would be that the Under Secretary speak on behalf of the Department. I think she would explain that Dr. Cooper and I would play a followup role after she introduces the subject.

Mr. VANDER VEEN. Thank you very much. First, let me thank you for appearing here before the subcommittee. We are very pleased to have you. Will you please proceed.

STATEMENT OF MARJORIE LYNCH, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JAMES B. CARDWELL, COMMISSIONER OF SOCIAL SECURITY; AND DR. THEODORE COOPER, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mrs. LYNCH. Thank you, Mr. Chairman and members of the subcommittee.

I am happy to appear before you for the first time and to have with me Dr. Theodore Cooper, our Assistant Secretary for Health; and James Cardwell, our Commissioner of the Social Security Administration, today.

As you are probably aware, I am still fairly new in the Department but as I become more involved in the health financing research activities of the Department of Health, Education, and Welfare, I have found the scope of our research activities quite broad and the range of issues exceedingly complex.

The 1972 amendments to the Social Security Act called for major change in the medicare program, including its coverage and reimbursement methods. You asked us to focus our specific attention on section 222, which was written to encompass certain additional complex areas which had been proposed for medicare coverage, but about which the Congress felt too little was known.

Section 222 authorizes the Secretary to develop and carry out experiments and demonstration projects. These projects must be designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, skilled nursing facilities, and other providers of services.

The authority impacts on the medicare (title XVIII), medicaid (title XIX), and maternal and child health and crippled children (title V), programs.

In addition to the prospective reimbursement experiments, section 222 authorizes research in other substantive areas. These research areas include: negotiated rates and other incentive reimbursement and State rate-setting and fixed price or performance incentive contracting to intermediaries and carriers.

Other research areas encompass alternatives to institutional care such as day care, day hospitalization and homemaker services. The statute also authorizes experiments relating to reimbursement for clinical psychologist services, physician extender services, and other noncovered services such as ambulatory surgery.

The Department has been provided with a continuing challenge in our implementation of this statute. We were charged with the enormously difficult task of charting a new course of research in areas where there were a variety of viewpoints, and certainly an absence of easy answers, and not even a generally accepted research methodology.

In describing our implementation, it might be helpful if I briefly outline the division of experimental responsibilities within the Department. The Office of the Assistant Secretary for Health, the Social Security Administration, and the Social and Rehabilitation Service are the agencies which share responsibility for developing, conducting, and evaluating demonstration projects and experiments. In all cases, they help each other in reviewing proposals, resolving issues raised during project implementation, and monitoring and evaluating the projects.

The Assistant Secretary for Health has the responsibility for assuring the appropriate health perspective for all these activities in the Department.

The Social Security Administration has the lead responsibility for determining the effectiveness, efficiencies, and economies of fixed-price or performance-incentive contracts for intermediaries and carriers.

The Social Security Administration is conducting a major study of reimbursement for physician assistant services. SSA also has lead responsibility for conducting a study of direct reimbursement services for clinical psychologists' services and a study of the effects of extending coverage to services performed in ambulatory surgery centers.

Under the Assistant Secretary for Health, the Health Resources Administration has the lead responsibility for developing and evaluating experiments to test whether payment for services which are incidental to currently covered services would result in more efficient and economical provision of the covered services. The Assistant Secretary for Health also conducts benefit package experimentation in alternatives to long-term care institutionalization.

The Social and Rehabilitation Service has a cooperative working relationship with the other two agencies as well as conducting related experiments. I know the subcommittee is familiar with the recent section 222 demonstration undertaken by the medicaid program with the State of California to develop a model State quality assessment and cost-control monitoring system for prepaid health plans. Mr. Chairman, I wish to emphasize that the Department conducts related health financing research under many different authorities. There are various other components of the Department, such as the Office of my Assistant Secretary for Planning and Evaluation, which we have not

even mentioned in our discussion today. I would like to submit for the record a listing of our various legislative authorities under which we conduct this research.

I also wish to stress to you the close cooperation that is involved in our administration of the experimental authority granted under section 222. One illustration of this close cooperation is the Social Security Administration's authority to grant waivers to permit medicare reimbursement under projects concerning homemaker, day care, and incidental services which are conducted by the Health Resources Administration under the Assistant Secretary for Health. SSA also serves as the fiscal intermediary for these projects. This does not mean that there are no areas of disagreement with regard to individual research projects. It is my firm belief that this kind of "give and take" is healthy and will, in the long run, insure the maximum payoff from our investment.

As you may know, Mr. Chairman, I am originally from England—a country which embraced a national health financing system before there were answers to many crucial questions. That initial decision created tremendous operational complexities for making future changes. I believe that our Congress was very wise in attempting to insure that we had some of the research completed and evaluated before we embarked upon bold changes in our health financing system.

I know that you have expressed a concern regarding the time lag between passage of the legislation and awarding of all contracts. It has been just 3 years since the Department received its new experimental authority. Let me stress a point that I mentioned to you before—that the Department faced a variety of viewpoints, both internal and external, on how best to proceed. Obviously, we were not able to initiate every project immediately. While people within the Department, the interest groups, and Congress shared an anxiousness to begin implementation research priorities were naturally different. Within the Department, this has insured that funded projects were subjected to a rigorous examination. Again, I believe that in the long run, we will all be the beneficiaries of this spirited internal dialog.

I would like to stress, Mr. Chairman, that there is an internal appeal mechanism to the Secretary if there is unresolved conflict among the agencies. I went to assure you also of my own personal interest and awareness of my oversight responsibilities as Under Secretary of the Department.

We have also been challenged by our constantly changing parameters. To date, our results for the most part are inconclusive, but we must remember that our health system has not stood still.

An important point to note is that most of our research involves long-range projects, rather than short-term studies. We at the Department share your concerns regarding long-range policy guidance. Although we have faced tremendous challenges which may not have permitted the early achievement of clear results, we are confident that our ongoing projects nad future work will yield research findings which will be of value not only to the medicare and medicaid programs, but to the health industry and country as a whole.

I appreciate the invitation to appear here today, Mr. Chairman.

I would like to ask Dr. Cooper and Mr. Cardwell to answer your questions at this time. Thank you.

[Documents mentioned follow:]

RESEARCH AUTHORITIES RELEVANT TO PUBLIC LAW 92-603, SECTION 222 RESEARCH FUNCTIONAL[1] AREAS (BY DHEW COMPONENT)

I. Public Health Service

A. ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

1. National Institute of Mental Health

a. Benefits: PHS Act, Sections 301–303.
b. Clinical Psychologists: PHS Act, Sections 301–303.
c. Financing Mental Health Care under Third Party Reimbursement Systems: PHS Act, Sections 301–303.

2. National Institute on Drug Abuse

a. Benefits: PHS Act, Section 301.
b. Manpower: PHS Act, Sections 301–303.

3. National Institute on Alcohol Abuse and Alcoholism

a. Benefits: Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Section 311.
b. Manpower: Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Section 311.

B. HEALTH RESOURCES ADMINISTRATION

1. National Center for Health Services Research

a. Reimbursement: PHS Act, Sections 304–305.
b. Methods of Payment: PHS Act, Sections 304–305.
c. Benefits: Section 222 and PHS Act, Sections 304–305.
d. State Rate Setting:[2] PHS Act, Sections 304–305.
e. Long Term Care Services: Section 222 and PHS Act, Sections 304—305.
f. Manpower: PHS Act, Sections 304–305.

2. Bureau of Health Planning and Resources Development

a. State Rate Setting: Section 1533[3] (Public Law 93–641).

3. Bureau of Health Manpower

a. Manpower: PHS Act, Section 774.

C. HEALTH SERVICES ADMINISTRATION

1. Bureau of Community Health Services

a. Benefits:
1. Maternal and Child Health: Section 512 (Social Security Act).
2. Migrant Hospitalization: Section 319 PHS Act.
b. Long Term Care Services: Section 512 (Social Security Act).
c. Manpower: Section 512 (Social Security Act).

2. Bureau of Quality Assurance

a. Long Term Care Services (Home Health): Public Law 94–63, Section 602 and PHS Act, Sections 304–305.
b. Benefits (Incidental Services—Home Dialysis Assistance): Section 222.

II. Social Security Administration

A. OFFICE OF RESEARCH AND STATISTICS

1. Prospective Reimbursement: Section 222.
2. Methods of Payment: Section 222.
3. Benefits (Ambulatory Surgery): Section 222.
4. State Rate Setting: Section 222 and Section 1526 of Public Law 93–641.
5. Payment for Teaching Activities and Care: Section 222.
6. Long Term Care Services: Section 222.
7. Manpower: Section 222.
8. Clinical Psychologists: Section 222.

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[1] See Functional Areas (described on pages 6 and 7).
[2] In view of current research by the Office of Research and Statistics, SSA, under Section 222 and the National Health Planning and Resources Development Act of 1974, P.L. 93–641. Section 1526, the NCHSR is not funding projects in this functional area.
[3] Technical Assistance and Research Dissemination.

B. BUREAU OF HEALTH INSURANCE

1. Fixed Price or Performance Incentive Contracting: Section 222.

III. Social and Rehabilitation Service

A. OFFICE OF PLANNING, RESEARCH AND EVALUATION [4]

1. Prospective Reimbursement: Section 222.
2. Methods of Payment: Social Security Act, Section 1115.
3. Benefits: Social Security Act, Section 1115.
4. Long Term Care Services: Social Security Act, Section 1115.

IV. Office of the Assistant Secretary for Planning and Evaluation

Health Experiment Funds: Section 232 or Public Law 93-644, "The Community Services Act of 1974."

V. Administration on Aging

Research and Demonstrations: Title III, Older Americans Act of 1974 as amended.

THE SOCIAL SECURITY AMENDMENTS OF 1972 PUBLIC LAW 92-603, SECTION 222 (a) AND (b) [5]

Experimental and demonstration functional areas

Summary of functional area	*Reference (sec.)*
1. Prospective reimbursement of hospitals, skilled nursing facilities and other providers of service.	222(a).
2. Changes in methods of payment or reimbursement, other than prospective reimbursement, including negotiated rates utilizing incentives to increase economy and efficiency.	222(b)(1) to 402(a)(1)(A).
3. Benefit package or incidental services research: Studies to determine whether payment for services other than those currently reimbursable would result in more economical provision or effective utilization of those services which are now covered. These new services must be furnished by organizations or institutions capable of providing: a. Comprehensive health care services. b. Mental health care services. c. Ambulatory health care services. d. Institutional services whic may substitute, at lower cost, hospital care.	222(b)(1) to 402(a)(1)(B).
4. State approval of rates of payment or reimbursement for health care provided under health programs established by the Social Security Act.	222(b)(1) to 402(a)(1)(C).
5. Payment of a single combined rate of reimbursement or charge for teaching activities and patient care in a graduate medical education program.	222(b)(1) to 402(a)(1)(D).
6. Homemaker and intermediate care facilities as alternatives to current posthospital benefits of the medicare program.	222(b)(1) to 402(a)(1)(E).
7. Fixed price or performance incentive contracting to improve program efficiency and economy.	222(b)(1) to 402(a)(1)(F).
8. Health Manpower: Studies to determine under what circumstances payment for the services of assistants to physicians would be appropriate and the most equitable and noninflationary method and amount of such payment.	222(b)(1) to 402(a)(1)(G).
9. An experimental program to provide day care services for individuals eligible for medicare part B and medicaid.	222(b)(1) to 402(a)(1)(H).
10. Clinical psychologists: Studies to determine whether the services of such personnel may be made more generally available to individuals eligible for medicare and medicaid.	222(b)(1) to 402(a)(1)(H).

[4] Projects are conducted by OPRE to assist in meeting the information needs of the Medical Services Administration which administers Title XIX. An OPRE staff member normally serves as Project Officer with program policy and management guidance provided by an Medical Services Administration Program Consultant.

[5] Section 222(b)(1) amends section 402(a) of the social security amendments of 1967.

Mr. VANDER VEEN. I thank you very much, Madam Secretary, for your agreeing to be here and to answer our invitation so graciously.

I appreciate your statement, which I think was an excellent one.

May I ask you, however, just before we turn to the gentlemen you mentioned, why there has been no formal legal delegation to this point, within my knowledge, of responsibility for section 222 and section 402 experiments?

Mrs. LYNCH. Mr. Chairman, I would like Dr. Cooper to answer that question.

Mr. VANDER VEEN. That is fine.

Dr. COOPER. Mr. Vander Veen, both Mr. Cardwell and myself could respond to that. I think that there were understandings of where the expertise within the Department lay.

As I understand the history of the implementation of that activity, there were memoranda that were exchanged between agencies and between the Secretary's Office and the agencies about how this would go.

I think that——

Mr. VANDER VEEN. If I can ask your pardon for interrupting you, it seems appropriate for me to call to your attention a memo from you to Mr. Cardwell in March of 1976 in which you said,

> We need to clarify our lines of responsibility for this important area of research and to resolve the delegation question before the oversight hearings on this subject.

Dr. COOPER. Yes: I wrote Mr. Cardwell this memorandum after we had received the inquiries and there had been some difference of opinion as to what was needed in the response.

I wish to point out that this is not the same as saying that there was a difficulty in executing the research that was going on.

Mr. VANDER VEEN. But you in March——

Dr. COOPER. In March I asked the Commissioner—and, of course, the Commissioner responded to me, as I am sure you also are aware—as to his interpretation of how the activity lay. He indicated to you that he had a package which is being prepared for submission to the Secretary to clarify on the delegation.

Mr. VANDER VEEN. I am aware of some 150 pages of material that was submitted.

May I ask you very simply: Has there been a formal legal delegation of responsibility for section 222 and section 402?

Dr. COOPER. No.

Mr. VANDER VEEN. Why not?

Dr. COOPER. I can't respond to that question, Mr. Vander Veen. It is not within my jurisdiction to answer that.

Mr. VANDER VEEN. Why, in your opinion, if you don't mind saying so?

Dr. COOPER. My own opinion is that the research work was underway, and the need for administrative clarification was not addressed until the questions were asked by your letters.

Mrs. LYNCH. Mr. Chairman, may I interrupt you?

Mr. VANDER VEEN. Yes. Certainly.

Mrs. LYNCH. It is at this particular point that I came into this situation because of this issue that was being raised.

What I was trying to point out in my testimony to you is that I feel there is cooperation between the Social Security Administration,

the Public Health Service, and the Social and Rehabilitation Service. We have had several meetings just recently. I think it is an issue that will be resolved very shortly.

Mr. VANDER VEEN. All right.

Mrs. LYNCH. You are correct that we have not issued the delegation, but I truly believe that all three of these agencies have been working together.

Mr. VANDER VEEN. There is no question, is there, in your mind about the necessity for reaching a determination?

Mrs. LYNCH. I think we have to reach a determination one way or another. However, at this particular time I am convinced that they are doing the job they should be doing.

Mr. VANDER VEEN. I think I understand the thrust of what you were saying and what, I repeat, was an excellent statement.

I do see, I think, the merit of give and take, as you put it, and thrashing out the best way to do these things.

On the other hand, we have heard testimony here today and at other hearings of this Oversight Subcommittee of cost saving projects which have not gone forward for, partly at least, the fact that there doesn't seem to be any proper or any particular place or any given place or any legal place for people to seek redress or to address their problems.

Wouldn't you agree?

Mrs. LYNCH. I have advised both Mr. Cardwell and Dr. Cooper that I will expect that those issues will be brought to my office and, if necessary, they will be brought to the Secretary's office.

I personally intend to play a much more active role in this area than I have in the past.

Mr. VANDER VEEN. That is very pleasing to hear. I appreciate that very much. Really, I think that is what this subcommittee was hoping to hear. We are very pleased that you have this attitude. We are looking forward very much, as I am sure you are, to a resolution of what everybody seems to agree is a serious problem.

I thank you very much for your statement.

Mrs. LYNCH. Thank you, Mr. Chairman.

Mr. VANDER VEEN. Dr. Cooper, do you wish to add to the statements or to make a statement?

Dr. COOPER. I have a 25-page written statement, Mr. Chairman.

Mr. VANDER VEEN. I really didn't mean a 25-page statement.

Dr. COOPER. I can submit it for the record in some detail, if that is acceptable to you.

[The prepared statement follows:]

STATEMENT OF THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH

Mr. Chairman and members of the committee, Section 222 of the Social Security Amendments of 1972 authorizes research, demonstrations, and experimentation designed to test the cost-effectiveness and appropriateness of a number of changes in our methods of reimbursing for health services currently covered under Titles XVIII, XIX, and V, as well as the cost-effectiveness of alternative services which have been proposed for coverage under federally-supported health financing programs. The Department has made several reports to the Congress describing research activities and preliminary findings of its research supported under the Section 222 authority.

As the Under Secretary described, many organizational components of the Department engage in research relevant to the authorities of Section 222. Before proceeding to a discussion of the particular research activities which the Department has undertaken, I would like to discuss briefly some of our general perceptions about this kind of research.

In 1972, when Section 222 was enacted, a number of changes were made in the Medicare program and in its coverage and reimbursement methods (including coverage of renal disease treatment, Section 223 for limiting hospital reimbursement based on classifications of hospitals, Section 224 for limiting physician reimbursement based on an economic index, and Professional Standards Review Organizations—to mention just four such major changes). Some very important studies were later mandated, including the studies of the reimbursement of teaching hospitals and of physician reimbursement in order to judge the desirability of Section 227.

The substantive areas of Section 222—prospective and incentive reimbursement, day care, day hospitalization, and homemaker services as alternatives to institutional care, ambulatory surgery, as well as the reimbursement for clinical psychologist services or physician extender services—are very complex issues about which the Congress wanted additional information on which to base a decision on possible Medicare coverage. The study of each of these areas requires awareness of the total system context, while the system is constantly evolving. The economy, and particularly the health care economy, has been one of the most rapidly changing aspects of the total system context during the past four years, especially with the impact of the introduction and subsequent phase-out of the Economic Stabilization Program of the Cost-of-Living Council. In short, the system will not stay still long enough to be studied carefully. Many of the fundamental assumptions on which the concepts of incentive and prospective reimbursement were based became untestable during the course of our early studies as a consequence of changes in the economy.

Another general problem which has become apparent in the course of our Section 222 activities is the enormous difficulty of setting up experimental reimbursement systems or experimental service delivery systems so that they can then be evaluated. In attempting to set up experimental systems we have encountered a series of problems. Some of these experiments require the development of new methodologies; some require the development of special new reimbursement systems or arrangements; some require special cooperation and changes in the traditional practices of providers and the behavior of patients; some require changes in Federal, State, and local intergovernmental relations; some require all these changes. The evaluation of the cost-effectiveness of these experiments is another overall problem area. Part of the problem is one of methodology; there is no one generally accepted research method for determining the cost-effectiveness of health care services. Costs are difficult enough to measure; effectiveness is even more difficult, involving as it must assessments of outcome and the societal value placed on achieving that outcome.

It was perhaps overly optimistic for anyone to assume that system changes of this magnitude could be accomplished in many substantive areas in just a few years. A wise person recently remarked that if people think we do not have a health care system, just let them try to change it.

I hope my remarks will not be taken as excessively negative, because I believe that we have learned a number of important things. It is often the case in health services research that we learn how not to do things, but that in itself is a very important thing to know. It is also true that we often learn how to design better research approaches as well as learning other information about the functioning of the health care system beyond those aspects being specifically studied.

My last general point is that we see Section 222, as well as our other relevant research authorities, as a learning mechanism. Research is never policy-determining; at best, it is policy-informing, and, at worst, it is irrelevant. These research activities have provided important policy information, and now have the promise of providing us much more in the next few years to inform national policy development on the pace and structure of future national health insurance.

Research and Experimentation Under the Authority of Section 222 of P.L. 92-603

LONG-TERM CARE—ALTERNATIVES TO INSTITUTIONALIZATION

Day Care and Homemaker Services

In response to the legislative enactment of Section 222, a DHEW coordinating group was convened in 1973, representing SSA, SRS, HRA, ADAMHA, Office of Nursing Home Affairs and staff of the National Center for Health Services Research. This coordinating group reviewed the state of the field in long term care, and developed staff papers relative to studies completed, as well as possible

opportunities for demonstrations and experiments and potential research designs. In specific response to the legislation, attention was directed to intermediate care facilities, homemaker and day care services. The NCHSR initiated a state-of-the-art study of adult day care centers which attempted to provide a background analysis on staffing patterns, cost experiences and definition of services.

By the spring of 1974 a contract Request for Proposal (RFP) had been published and contract proposals were received from a variety of agencies in response to requests for these proposals. NCHSR, therefore, selected from among 23 proposals, six that appeared to be responsive to the priorities of the legislation and the proposed research and experimental design. A grant application that had been in process and development since 1972 was also awarded to develop an experiment in day hospital care for rehabilitation. A contract for one overall evaluation of the experiments was also awarded. No acceptable responses were received to permit inclusion of intermedite care facilities in these experimental evaluations.

Results

The Day Care Study.—The primary objective of the adult day care study was intended to produce baseline information that would contribute to the development of the adult day care experiments under Section 222. The objective was to determine whether or not alternative models of adult day care could be postulated from existing experience in the field. A representative sample of adult day care centers, established to meet health maintenance, social needs and rehabilitation therapy was selected for study.

Findings from the study indicated that two distinct models of day care had emerged. These were differentiated significantly by services provided, staffing patterns, participant characteristics and operating costs. The first model is characterized by relatively heavy emphasis on health services, utilizing a high ratio of registered nurses and professional therapists. Most of the patients have suffered serious illness, need rehabilitative care and are dependent for assistance with three or more essential activities of daily living, including the use of wheelchairs. The second model emphasizes daytime supervision for generally less impaired patients. Staffing patterns show a small proportion of professional nurses and therapists with more aides than in the first model. The cost range showed the range from between $20 to $60 for the high intensity medical care model and an average daily range of costs of between $11 and $25 for the less intensive model.

Homemaker and Day Care Demonstration Experiments

We have submitted extensive information on these projects to the Committee. These experiments were developed to test alternative models of delivery of long term care services, attempting to test and demonstrate whether or not ambulatory modes of care could be as effective and less costly than more traditional institutional modes of delivery. Six demonstration sites were selected as follows: San Francisco—combination day care and homemaker; Lexington—combination day care and homemaker; White Plains, N.Y.—day care only; Syracuse, N.Y.—day care only; Los Angeles, Calif.—homemaker; and Providence, R.I.—homemaker.

The major objectives of the demonstration studies and the evaluation of these is to test the impact of expanding benefits to be covered under Medicare programs to include day care and homemaker benefits, and to see whether these new benefits have an impact on either the client's health and functional status or total cost of providing these or traditional services. Specifically, the evaluation will provide (1) a description of the demonstration programs; (2) an analysis of provider services and costs; (3) an analysis of patient health services utilization and expenditure; and (4) any analysis of patient health outcomes. Patients in the demonstration experiments will be divided into two study populations (1) an expanded benefit group will be eligible for day care and/or health benefits for one year after eligibility is determined; and (2) the other group agreeing to participate will receive only currently covered benefits.

An analysis of costs, utilization and health outcome will make comparisons between expanded benefit groups and the traditional benefits group.

Approximately 1600 clients are participating in the experiments. Actual patient services started in May of 1975. The period between initial contract awards, June 1974 and May 1975, was spent in clarifying the research design and protocols, training staff at each of the demonstration sites in the use of these instruments, cost analysis and reimbursement methods, and developing client referral patterns within the community.

Findings to date suggest that the expansion of community day care services is often hampered in the early developmental stages by low rates of referral and utilization. Our time, as traditional provides and other referral sources become more familiar with these services, the rate of utilization and referrals increases. Preliminary data on utilization of clients receiving expanded benefits in these demonstrations show that most day care and homemaker clients use the services between two and three times a week. The benefits are available for the day care and homemaker clients up to one year after eligibility is determined; thus, the benefit period for some clients expired effective May 1, 1976, and it is still too early to determine how many and what kind of clients require services beyond the one year period of the experiment.

Other findings from the demonstrations indicate major technical difficulties in implementing a uniform protocol at disparate sites where there has been a strong service orientation rather than a research tradition. Staff of NCHSR, complemented by staff of a centralized evaluation contractor and staff of SSA have worked extensively with each of the projects to try to maintain data and research protocol integrity. Early indications show that participating providers and clients receiving the expanded benefits are generally pleased with these new benefits. The results of these six projects can be expected primarily to answer questions of cost and benefits related to specific cases using homemaker and day care services. It will not be possible from this limited series of demonstrations with one year of eligibility to answer broader questions concerning day care and homemaker services.

COORDINATED DELIVERY OF COMPREHENSIVE SERVICES TO THE ELDERLY

Project Triage, cooperatively funded by the State of Connecticut and the DHEW, has also been described to the Committee in several prior reports. Project Triage provides for a single-entry system involving the assessment of client needs, and the coordination and development of services to the elderly in a 7-town region of Central Connecticut. This experimental service model is now fully operational with trust fund reimbursement for comprehensive health and social services in keeping with a plan of care developed by nurse-clinicians based on a health and functioning status assessment of the client. Referrals are accepted from any source, including families, friends or self-referral, as well as from traditional providers; over 1000 persons have been referred to Project Triage since March 1974. Where needed services do not exist, Triage Inc. works to develop such services in the 7-town region. The evaluation of the cost-effectiveness of Project Triage is being conducted by the University of Connecticut in accordance with a research protocol approved in March 1976 which has been under refinement for the past year. The evaluation project, which is supported by the NCHSR, will compare services prescribed, services received, and changes in functioning status over time; cost-effectiveness will be judged on the basis of the relation between costs of services and improvement or slowed deterioration in functioning compared to persons in two other groups who have access to traditional services and traditional reimbursement.

Of particular policy interest in this project, is the concept of the single-entry service coordination mechanism whose cost-effectiveness can be evaluated separately from the evaluation of the total experiment. This is also the most comprehensive of our benefit-package experiments, and has provided valuable experience in learning and overcoming difficulties of such experimentation at the community, State, and Federal levels. The Division of Direct Reimbursement, SSA, has served as the fiscal intermediary on this project as well as on the homemaker and day-care and migrant projects, and the experimental reimbursement expertise which they have developed in this role has proved invaluable to the Department's implementation of these benefit-package experiments.

Future Plans

To expand our research knowledge concerning the full range of long-term care alternatives, the National Center for Health Services Research has recently announced a $1 million research solicitation in long-term care; applications are to be received by July 1 for funding in FY 1977. Future planning for other Section 222 activities will be dependent on the budget level of the NCHSR as well as the other relevant research-supporting agencies of the PHS. These benefit package experiments are very expensive in terms of research funds and in staff resources needed to oversee implementation and evaluation. Therefore, to provide a sound basis for future planning, it is important to complete the projects

underway and assure a detailed assessment on both the methodology and the findings. In 1977, assessments of these projects will provide the basis for planning additional research and policy recommendations concerning these alternatives to long-term care institutionalization.

RESEARCH, DEMONSTRATION, AND EXPERIMENTAL ACTIVITIES RELEVANT TO SECTION 222 AUTHORITIES

Title V—Maternal and Child Health and Crippled Children's Services Research Grants Program—Bureau of Community Health Services (HSA)

The program of grants for research relating to maternal and child health and crippled children's services was authorized by the 88th Congress under the Title V Maternal and Child Health and Mental Retardation Planning Amendments of 1963. This authority was provided to help improve the operation, functioning, general usefulness, and effectiveness of maternal and child health services and crippled children's services by providing financial support for scientific studies that may contribute to the advancement of health services for mothers and children. Special emphasis is accorded to projects which will help in studying needs, feasibility, costs, and effectiveness of comprehensive health care programs in which maximum use is made of health personnel with varying levels of training; another priority is the study of methods of training for such programs. Grants may be made to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or in maternal and child health or crippled children's programs. Fifty-eight projects were funded in Fiscal Year 1975 with an obligation of $5,873,660. $5.3 million is available for support of research projects in Fiscal Year 1976.

Several current projects funded under the authority of Title V have special applicability to those areas of research specified in Section 222. I would like briefly to highlight some of these Title V projects. Five projects are investigating the effective utilization of nonphysician care providers in maternal and child health services. One study in primary child health services contrasts two care systems in their base of operation (hospital vs. neighborhood clinic), in emphasis (problem resolution vs. prevention), and in principal technologies applied (physician vs. nurse clinician, paramedical and subprofessional). Another study is evaluating a home intervention program which has been set up to foster developmental processes in high-risk prematures. Another study evaluates genetic counseling given by physicians and paramedical personnel. Two other studies focus on services provided to adolescents by nonphysician providers.

Three projects are investigating the needs and cost of various levels of care in child health services. By the use of programmed learning and a consultative service, one study in regionalization of neonatal care is demonstrating the ability to increase the effectiveness of neonatal care in the community hospital setting. A second study is looking at levels of required care and demands on resources. The third study is looking at the effectiveness of alternate types of day care for children under three years of age.

Seven projects are investigating the efficacy of preventive measures and training of health personnel in order to improve services and decrease costs. Areas of study include alternate methods of preventive dental health measures in an elementary school setting; testing developmental assessment procedures and investigating the relationship between early health screening and health outcomes; development of programmed instruction in child growth and development for professional and auxiliary health personnel; development of a methodology to evaluate the performance of pediatric residents in delivering ambulatory health care including estimates of cost for an established audit program; development of a battery of tests with which to identify parents who have potential for abuse and/neglect of infants and children; adolescent health care; and development of a predictive model of performance of health care delivery facilities.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH (HRA)

1. Other Health Financing Research

Expanding our capacity to predict and to evaluate the possible outcomes of various national health policies is a priority concern of the National Center for Health Services Research. The research supported by the National Center which has addressed the policy questions related to insurance and health care financing has necessarily engaged a wide range of interrelated empirical issues. The stud-

ies directly related to the research authorized by Section 222 of the Social Security Amendments of 1972 involve analysis of the relative cost-effectiveness of alternative insurance benefit packages. The National Center is also supporting a number of studies that examine the implications and potential consequences of insuring against catastrophic health occurrences. The National Center, in addition, continues to support research that explores the structural relationships that may influence and alter the impact of insurance on the cost and distribution of health services. An understanding of these underlying factors is essential to analysis of the possible outcomes of different financing arrangements in order to inform policy development.

What might be called "the demand response to health insurance" is an issue of major importance in the examination of these structural relationships. Several of the studies funded by the National Center have addressed the factors, both financial and non-financial, which among different segments of the population are likely to differentially affect the consumption of and the ability to pay for various health services. Assessment of the impact of a reduction in money prices on the demand for selected services, the role of coinsurance and deductibles in moderating the demand for services, and the effect of waiting and travel time on the demand for ambulatory care are issues of particular concern. Several NCHSR contractors are also examining the effects of adverse national economic conditions (and reduced ability to pay) on the use of public vs. voluntary facilities, health status, state and local health financing, use of emergency and outpatient facilities, and loss of insurance coverage. Distributive aspects of health care financing have been examined in the context of Federal tax policy and deductions for private contributions to health insurance. Finally, as a result of a major health expenditure survey that it is currently sponsoring, the National Center will soon have the capacity to extensively simulate the impact, in terms of both cost and equity, of various health care financing options.

A second set of structural issues that have been examined with the support of the National Center can be categorized as "the supply response to health insurance." These studies are concerned with the impact of financing on provider production and pricing decisions, and the relationship between these decisions and accelerated inflation in the health service industry. A major focus has been the potential response of providers to implementation of national health insurance, particularly in regard to the question of whether or not the supply of ambulatory care services will respond adequately to increased demand. Other studies address the factors underlying variations and changes in service intensity in hospitals, changes in treatment costs of selected illnesses, and the role of technology in the generation of a more sophisticated and expensive hospital product. The National Center also continues to examine the effects of alternative physician and patient payment mechanisms on prices charged to consumers, on the cost and supply of physician services, and on physician productivity. Other Center studies have assessed physician manpower requirements under alternative health insurance provisions.

Various health insurance proposals have included regulatory programs designed to control the inflation of health care prices and costs. The National Center has supported research to evaluate the effectiveness of such programs. These studies have examined the impact of the Economic Stabilization Program and certificate-of-need legislation on the structure and organization of health services delivery, as well as their effect on health care prices.

2. Health Manpower

The health care industry is one of the most labor-intensive industries in the American economy. Health care costs and access are likely to be profoundly affected by the occupational and geographical distribution of the health labor force, by the efficiency with which personnel are trained and utilized, and by factors determining health industry wages. Research focused on the health labor force is consequently an important element in the search for solutions to national health care problems.

To date, most of the studies of health manpower supported by the National Center have examined the feasibility and advisability of finding less costly labor and technological substitutes for scarce and expensive manpower, especially for physicians. The labor substitution studies supported by the National Center have focused almost entirely on the problem of relieving the physician of routine clinical tasks that provide the information for therapeutic decisions. On the basis of these studies it would appear that physician substitutes may be espe-

cially effective in providing primary care—care whose content is characterized by the taking of a history, execution of routine and relatively simple laboratory tests, treatment with simple technology and referral for obviously complicated problems. The physician extender approach seems particularly well adapted to delivering services of this nature. The evaluation of the physician substitute has not been completed; the National Center intends to examine more closely the nonphysician labor market, where the cost and availability of health services may be significantly affected by mobility patterns, employment practices, and the growth of collective bargaining. Studies and findings illustrative of the research which has been undertaken are summarized below.

An essential prerequisite to the acceptance of physician substitutes is evidence that their use will not adversely affect the quality of care. The diagnostic skills of interns in the Child Health Associate Program at the University of Colorado were studied by comparing their diagnoses for a variety of ambulatory pediatric patients to the diagnoses of practicing pediatricians. It was found that the physician substitutes and the pediatricians made similar diagnoses in 131 out of 143 cases (91.6%). Seventy-one percent of the patients interviewed in a Dartmouth Medex program survey reported that the quality of care as they perceived it had improved after the Medex, a former medical corpsman who has received three months of intensive classroom training followed by a nine month internship, joined their physician's practice. Physician perceptions of the care provided by physician substitutes seem to be equally favorable. Fifty percent of the physician preceptors surveyed by the Utah Medex Program maintained that the quality of services provided in their practices had improved after employment of the Medex.

If greater physician productivity results from employment of physician substitutes, then the use of physician substitutes should increase the available supply of services and make health care more accessible in areas where such services are scarce. In the Medex practices that were the subject of one research study, the average number of patient visits per day increased by approximately 12% by the end of the first year of employing a physician substitute. By the second year, the average daily patient load had increased by 37%. A Utah survey has shown that the use of a physician assistant also seems to change the nature of visits to the physician. Sixty-nine percent of the physicians reported that they were able to spend more time with each patient, especially patients with serious medical problems.

The National Center has also supported research to examine the financial consequences of substituting lower salaried workers for the physician. According to one such study, the provider cost per patient visit for patients seen by a Child Health Associate at an inner city neighborhood health center was $3.92 during the first year of employment, compared to $6.75 for the full time pediatricians' services. The difference in cost could not be explained by differences in the type of patients seen by the substitute. Another research project conducted by the Dartmouth Medex program showed that in ten of the twelve practices under observation the physician derived a substantial estimated profit by employing a physician assistant. Two investigations undertaken at the University of Washington which examined actual (rather than estimated) profitability did not substantiate this finding. The National Center is now supporting several other studies that should provide more definitive information about the cost-effectiveness of physician substitutes.

Another broad area of research supported by the National Center is aimed at facilitating the delegation of tasks to physician assistants. Clinical protocols have been developed which describe the appropriate steps to be taken in the management of specific patient complaints. One study demonstrated that individuals with high school degrees and only four weeks of formal training could use these protocols to effectively monitor and treat patients with diabetes and hypertension. This approach led to a 20% saving in physician time, and greater thoroughness in the collection of clinical data. A different approach to nonphysician support systems has been to explore the use of telecommunications equipment to link physician extenders with supporting physicians from whom they are geographically separated. One project showed that the telecommunications system improved access to primary care by facilitating a more expanded role for the nurse practitioners working in an inner city neighborhood health center. Access to specialist services was also improved, since patients were apparently more likely to keep their referral appointments when they had already consulted the specialist over the television link.

The National Center also supports research which focuses on the direct substitution of technology for the physician's time. The evaluation of computer-assisted electrocardiogram analysis has shown, for example, that the use of computers for this purpose reduces the time spent interpreting electrocardiograms and recording and storing reports. Hospitals using this new technology were able to limit the cost of an EKG to $10 while increasing by 18% the number processed.

3. Bureau of Health Manpower

The Bureau of Health Manpower (HRA) also supports research on physician extenders. One study of the potential cost-savings from utilizing physician assistants in prepaid group practice as substitutes for physician services found significant potential cost savings in a prepaid setting with no adverse impact on quality of care.

4. Bureau of Health Planning and Resources Development (HRA)

The Bureau of Health Planning and Resources Development has significant technical assistance and research dissemination functions relevant to Section 222. The authority to support up to six State rate-setting demonstrations authorized by Section 1526 of P.L. 93–641 has been delegated to the Social Security Administration to be implemented in conjunction with the prospective reimbursement and rate-setting experimentation under Section 222. The integration of the results of these studies with certification of need, reviews for appropriateness, and other health planning activities and the dissemination of information to all the States and the Health Systems Agencies authorized under P.L. 93–641 will have an important long-range influence on the future of health care.

5. Alcohol, Drug Abuse, and Mental Health Administration

ADAMHA activities relevant to Section 222 fall within the areas of benefit-package changes (including long-term care alternatives), and evaluation of alternative auxiliary service manpower. Both the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse have developed model benefit packages for the coverage of alcoholism and drug abuse services. California has initiated a pilot alcoholism occupational health insurance program for all State employees and their families, which is based on the NIAAA model benefit package; all insurance carriers currently offering basic health care coverage to California State employees have agreed to participate in the program, and NIAAA is currently evaluating this program. The model drug abuse benefit plan includes a flexible range of services emphasizing non-in-patient care, and reduction of lengths of stay for inpatient care to a minimum.

Counselor certification standards have been developed leading toward State certification of non-degreed professional alcoholism treatment personnel. As a basis for certification, NIAAA recently funded a study to develop model standards by means of a survey of alcoholism programs employing alcoholism counselors, with selected site visits to verify data. Over 2000 institutions and associations in the alcoholism field reviewed the draft standards.

In the development of alternative auxiliary manpower, NIDA has also emphasized credentialing to provide quality assurance. The present NIDA credentialing contract has provided a Status Report of Credentialing Activities and a functional job analysis to provide a consistent description of the functions and activities of workers. NIDA has involved the States in task analysis, full credentialing models instituted at the State level, and State task forces to develop a credentialing process.

The National Institute of Mental Health and the Health Resources Administration have jointly funded a retrospective study of the experiences under Title XIX to assess the merits of assigning clinical psychologists independent practitioner status in a study authorized under Section 222. BLK Group, Inc. completed the study and recommended to the Department that psychologists be given such status and that a monitoring program be established for the Department to continue to evaluate the experience. SSA is now conducting a similar study in the State of Colorado for the Medicare population only.

The Community Mental Health Centers Program represents one of the largest Federal, State, and local investments to provide alternatives to long-term institutional care. Evaluations of this program have documented the effectiveness of such community based services in avoiding inappropriate institutionalization of the mentally ill. NIMH is also supporting a contract to develop a

research design for the study of the impact of granting CMHC's provider/vendor status under Titles XVIII and XIX.

6. Other Activities of the Bureau of Community Health Services (HSA)

a. *Migrant Hospitalization.*—The Bureau of Community Health Services' hospitalization program for migrants is designed to provide inpatient hospital services including medical services for migrant agricultural workers and their dependents through a limited number of migrant health projects. Projects must provide comprehensive, full-time medical services on a year round basis where there is no other source of hospitalization support. These projects certify the eligibility of patients for care under the program and refer the patients to a participating hospital. The participating hospitals are reimbursed for services on a predetermined all inclusive per diem rate by the Division of Direct Reimbursement, Bureau of Health Insurance, SSA. Hospitals are reimbursed based on the lower of their costs or charges. Physicians are reimbursed at the area prevailing rate or the individual physician's usual and customary rate, whichever is lower.

b. *Home Health Services.*—P.L. 94–63 added a one year provision for grants for the establishment, initial operation and expansion of existing home health services, and the training of professional and paraprofessional personnel.

These grants, which are to be awarded this summer, will expand home health services by demonstrating innovative approaches to the development or expansion of home health services—particularly in areas serving a high percentage of persons who are elderly or medically indigent, or both. They should also serve as additional sites for the evaluation of home health services.

c. *Incidental Services for Home Dialysis Assistance.*—A 222 study to begin to analyze the impact of making home health aides available to home dialysis patients is being designed to begin early in Fiscal Year 1977. During the study, selected home dialysis patients will be offered several options: 1) assistance at home during their first 1–2 dialyses and 2) the use of a home dialysis aide up to 20 times per year to relieve the burden on the voluntary aide. Among the effects to be analyzed are: (1) any change in the number of backup (in-center) dialyses done; (2) differences in the rate of return to permanent in-center dialysis; (3) changes in the number or type of physician contacts; and (4) changes in the health, vocational or psycho-social status of patients offered these added benefits compared to those not offered them.

d. *Related Activities of the Administration on Aging.*—Under the Older Americans Act, the Administration on Aging within the Office of the Assistant Secretary for Human Development has provided financial and other support to many efforts to reduce the need for institutionalization of older persons with mental or physical impairmnets. State and Area Agencies on Aging have been encouraged to stimulate and coordinate social and health services designed to increase opportunities for the impaired to obtain supported services in their homes when appropriate, or to obtain less intensive and costly personal or residential care when this can eliminate or postpone more intensive 24-hour care.

In addition, discretionary grant and contract funds are supporting a series of Model Projects (provided for under Section 308 of the Act as amended in 1973, P.L. 93–29). These projects include:

The On Lok Senior Health Services Center, a licensed clinic, is providing non-institutional community based day care services to the elderly, primarily to limited English speaking, Chinese, Filipino and Italian populations of Chinatown, North Beach, and San Francisco, with major financial support by AoA since 1972.

The Burke Day Care Hospital in White Plains, New York, is demonstrating a medically oriented day care center originally designed as an alternative to nursing home care for elderly adults who were institutionalized because of unavailability of medical and nursing daytime supervision. The Hospital now serves those who require shorter periods of more intensive or rehabilitative treatment, and is one of the sites for the Section 222 homemaker/day care demonstrations.

Two major demonstrations support day care centers designed to prevent premature hospitalization by providing maintenance supportive and recreational services: Levindale Adult Day Treatment Program, Baltimore and the Moshula-Montefiore Geriatric Day Care Program in Bronx, New York.

The Urban Health Institute, East Orange, New Jersey, is demonstrating the use of preventive health education to reduce the impact of physical and mental impairment.

With Project "Heal," the Pima County Council on Aging is generating supportive care services to older people in their homes to prevent institutionalization.

The Papago Indian Tribe project is demonstrating how a homemaker program on a Reservation can reduce the need for institutionalization. Several other research and development projects supported under the Older Americans Act also contribute to this objective:

The Colorado Department of Institutions is testing use of specialized boarding homes for elderly persons who otherwise probably would be in mental institutions.

The International Center for Social Gerontology is reviewing European experience on congregate housing as an option.

Case Western Reserve University is assessing the extent to which certain economic and service incentives can induce and equip a family to provide home care for elderly members.

Dr. Cooper. In view of the nature of the preceding discussion, I think it would be iterative in a certain sense to go over some of the ground.

The only comment that I would want to make is that the notion that all these internal administrative problems are the essence of what you called in your statement "poor performance" were slow responses. I do not think that I could in conscience let that stand without some response.

Mr. Vander Veen. You are certainly entitled to respond to that. I hope you do. Please proceed.

Dr. Cooper. In that respect, Mr. Chairman, I think that there are many activities across the country that we would wish very much that we could implement, including demonstrations. At first blush many of these would seem to be the obvious ways to improve the health care system. Certainly, we are in favor of all the activities that were specified in the law which mandated this particular coverage experimentation.

I think that the contention, for example, that the previous witness, Dr. Steinbock, had about the expected cost saving of home services is a case in point. Here we have what obviously seems like a good thing to do—one which we were interested in and that we were interested in pursuing.

The notion that our difficulties with solving the administration of this was inhibiting the notion of proving, for example, that you could potentially get services for $120 that currently you paid $200 for has been exactly the problem. We have been faced with this in trying to explain to you what is our responsibility during a period of change in the financing system, during a period of great change in the economy, during difficulties in the authorities that are available under which these kinds of demonstrations could be made.

The notion that nothing had been done or nothing accomplished is the perception of this kind of a difficulty. This is what concerns me, and we ought to try to resolve it.

In reviewing the events of the past 3 years in preparation for both the answers to your and Mr. Vanik's letters, and these hearings, I have developed a good understanding of what the problems have been, what the issues are and what the performance in the system has been.

I do not feel that nothing has been learned, nor do I feel necessarily that the progress has been slow, when you measure it against what is technologically possible in the area.

Mr. VANDER VEEN. Dr. Cooper, if I may interrupt at that point, there can be a difference of opinion as to whether or not things have moved sufficiently rapidly or not. It does seem, however, to be the opinion of all concerned at this time that the time has come for a resolution of the matter of delegation of authority. You wouldn't disagree with that, would you?

Dr. COOPER. No, sir. I think the issue of delegation of authority is an issue that will help in many ways for administering the program. However, I do not think it will solve the real issues of frustration that we will still face with respect to obtaining the answers. I support the idea that this could help the process. I would work with the Commissioner and with the Under Secretary in order to resolve this. I have so discussed with them in the last several days.

Mr. VANDER VEEN. That is fine. We appreciate your reassurance very much.

At this point, if you will allow me, I would like to call on my colleague and fellow member of the subcommittee to see whether or not he has any questions. I know that he is pressed for time. There is a particular issue that he would like to inquire about.

Mr. Pickle?

Mr. PICKLE. Thank you, Mr. Chairman.

I have been engaged in floor activity until just a few minutes ago.

You many have touched on this. I want to know, has this panel, either collectively or individually, made a specific recommendation or a clear statement about how you feel about the prospective reimbursement approach? Or do you favor the prospective reimbursement approach? Can we use cost saving? Have we just been talking in general terms? Or do you have specific recommendations?

I would like to have discussion about section 222 and I think we can be encouraged if we are going to have closer attention to it. But have each one of you made your individual recommendations or are you going to? Or has that been done, Mr. Chairman?

Mr. VANDER VEEN. Each of the witnesses had a prepared statement which has been submitted for the record.

In response to my letter, there was a very extensive statement made. There were many recommendations.

What we focussed in on, Mr. Pickle, was the matter of the delegation of responsibility for effectuating section 222 and section 402.

It seems to have been agreed by the Under Secretary, by Dr. Cooper, and Commissioner Cardwell that we can make some progress if we will do this. That is what we have been spending our time doing.

The prepared statements of the witnesses do cover the point that you have raised, Mr. Pickle. So that hasn't been covered in the actual testimony here today.

Mr. PICKLE. As I say on section 222, if we can find better ways to actually carry that out, it would be helpful. I have a feeling that some of the biggest costs we have in the hospital care right now are in just personnel, recordkeeping. I imagine Mr. Cardwell will say that is maybe the biggest item we have.

Aside from a particular section, I want to know what is the best approach? I read these long discussions from my State about their hospitals and all their worries and discussions. We all know that these costs are going up, but what is the best approach? Is prospective reimbursement a better approach?

Commissioner CARDWELL. Mr. Chairman——

Mr. PICKLE. Would you recommend that? If you had the right to say we are going to do this approach or do that approach, what would you recommend?

Commissioner CARDWELL. Mr. Pickle, it seems to me that, as I am sure you appreciate, section 222 really has as its purpose explorations and testing and some demonstrations to either prove or disprove a theory, a hypothesis, if you will, that has come to the surface many times since the enactment of medicare and medicaid. Namely, that if our delivery system were to be reorganized in a way which would permit prospective fee setting, if you will, rather than payment after the fact or reimbursement of actual costs or estimated costs, two things would result.

(a) The system would function more efficiently and effectively for the population; and (b) Costs, the natural escalation of costs that seem to follow the present system, would be constrained. That is the theory.

I don't think anybody at this stage believe that prospective reimbursement or fee setting of one kind or another would ever turn costs back. However, they might constrain the natural forces that tend to push medical costs up.

The problem is that our medical delivery system is not so organized and the Congress and public policymakers generally have not been prepared or willing to make an abrupt change or to mandate an abrupt change in the fabric of the system. That is why we have this experimental authority. It is a kind of a probing or a testing, if you will.

No one, neither in the executive branch nor the legislative branch, that I know of, is prepared to come forward and advocate here and now that we shift to prospective reimbursement if for no other reason than the system itself would be literally turned inside out if you attempted to make such an abrupt shift.

I think almost everybody believes we are bent on an evolutionary pattern of changing the system and that experimentation is just a part of that evolutionary pattern.

In other words, we don't have any recommendations at this time.

Mr. PICKLE. You would make no recommendation until you have had a chance to see what the study shows?

Commissioner CARDWELL. That is right.

Dr. COOPER. I would support that, Mr. Pickle, with the further observation that the early studies support the contention that the variety of other forces during the recent few years, including the general economic system in the country made very difficult the interpretation of any of the observations resulting from the experiments. This had led at least to the conclusion in our minds that prospective reimbursement as a recommendation for immediate change should not be endorsed at this particular time from what we know.

That is one of the things that we have learned from some of these experiments. I think that we have to pursue the experiments in this regard.

Commissioner CARDWELL. We can tell you, Mr. Pickle, in fairly positive terms, as I point out in my statement—which I would like to file in the record, of course—that the incentive experiments that were sponsored under section 402 before enactment of section 222 do seem to show quite conclusively—and we are prepared to make this a flat statement—that the various incentive techniques that were explored will not be effective on a voluntary basis.

In other words, you cannot depend on the system itself to respond to these incentives in a way that would reduce costs. That is a lesson we might well learn. It may well end up that we may find that prospective reimbursement systems also may not function on a voluntary basis, unless they are mandated.

[The prepared statement follows:]

STATEMENT OF JAMES B. CARDWELL, COMMISSIONER OF SOCIAL SECURITY

Mr. Chairman and members of the subcommittee, I am pleased to have this opportunity to discuss with you the status of the Medicare research and experimentation program. In the 9 years since the enactment of legislation granting authority to conduct experiments in alternative methods of reimbursement under the Medicare program, we believe we have made substantial progress in identifying those areas that have the greatest potential for producing both program improvements and program savings. We recognize that there is much additional work to be done.

I will describe to you today the accomplishments we have made thus far, the problems we have encountered in our endeavors, and our plans for more wide-ranging experimentation in the future. I hope that this brief overview of our research efforts will give you some idea of the broad range of our activities, particularly since the enactment of the Social Security Amendments of 1972. To date, we have spent almost $19 million on Medicare research and experimentation, the vast majority of which has been spent since the 1972 legislation.

SUMMARY OF RESEARCH PROGRAM

Since the inception of the social security system in this country almost 40 years ago, SSA has maintained a keen interest in research concerning the program it administers. Research authority was granted to the Social Security Board by the 1935 legislation, and this authority has been employed since then not only to improve the functioning of the social security program but to expand the general body of knowledge concerning aging, disability, economic security, and related fields.

Following enactment of the Medicare legislation in 1965, SSA and the Department initiated research to determine what improvements could be made to increase the efficiency and economy of the program and to make it more responsive to the needs of beneficiaries. Throughout this period both SSA and the Department have focused attention, not only on Medicare, but on the overall operation of the health care industry. Our earliest health care research efforts were devoted primarily to the gathering of pertinent statistics and performance data. As the Medicare program matured and medical care prices continued to escalate, both the Department and the Congress experienced increasing frustration in attempting to determine effective ways of containing program costs without lowering the quality of care provided to beneficiaries. The enactment of provisions granting us authority to experiment with alternate methods of reimbursement—section 402 in 1967 and section 222 in 1972—reflected these frustrations and our continued determination to overcome them.

The major objective of the research we conduct is to test untried reimbursement methods in the hope of identifying approaches which produce program economies. The success of these efforts is never assured—or there would be no

need for experimentation. When a hypothesis fails to be upheld by experimental findings, we have, in effect, learned what doesn't work; and we have avoided a vastly more expensive failure on a broader scale. We have gained valuable knowledge from all of our research, and we can never afford to confuse the failure of a hypothesis with the failure of experimentation.

The Social Security Administration has conducted a variety of studies, developmental projects, demonstrations, and experiments since beginning our formal Medicare research program in 1967. Within the scope of the legislative directives, we have been guided by two broad principles in selecting which projects to undertake. First, we believe that we have a responsibility to focus our attention on those areas of the health care delivery system where the financial situation is most critical. Although health care costs are escalating rapidly in every facet of the industry, it is abundantly clear that hospital costs consume by far the largest portion of the Federal health care dollar, and that these costs show the greatest percentage increase from year to year. Thus, most of our efforts have been devoted to hospital reimbursement experimentation. Nevertheless, we have recently begun to enter into experiments dealing with physician fees and long-term care. Our progress in the physician fee area has been limited due to the fact that we do not have the same type of program participation agreements and financial arrangements with physicians that we have with the Nation's hospitals. Our second guiding principle is that in selecting specific projects within each subject area we have consistently directed research dollars toward those projects which offer the most potential for containing health care costs.

It should be noted here that our research programs have grown rapidly over the years. In fiscal year 1973, total obligations for SSA health insurance experiments and demonstration projects amounted to a little over one million dollars. In the early days there were impediments to our progress which were, for the most part, beyond our direct control. Expertise in testing and evaluating reimbursement mechanisms was virtually nonexistent within SSA and among the universities and foundations to whom we initially turned for assistance. As expertise increased over the years, both within SSA and elsewhere, we have been in a much better position to determine the direction of future experimentation. Thus, our total commitments for experiments and demonstration projects in fiscal year 1976 will amount to nearly $9 million.

Dr. Cooper's testimony addresses the variety of research projects being undertaken by the National Center for Health Services Research and other components involved in the total HEW research effort. I will therefore confine my testimony today to a discussion of those experiments and demonstration projects currently underway or in the planning stages within SSA.

Before I discuss the specifics of our research, I would like to describe the research plan which we have adopted to identify viable new methods of containing health care costs. The Office of Research and Statistics engages in three types of projects—studies, developmental projects, and experiments. Studies are conducted to augment knowledge in relatively uncharted areas. They provide us with the historical background and data which are necessary to proceed with the experiments. The developmental projects devise specific systems or methods intended for use in actual experiments. The experiments themselves include both demonstrations and evaluations. The demonstrations test the system or methodology which was developed during the developmental process. Evaluation of the experiment usually begins during the demonstration so that the evaluator may observe the experiment as it evolves. To ensure overall objectivity, the Office of Research and Statistics conducts evaluations separately from demonstrations. For this purpose, a separate Evaluative Studies Branch has been established within the Division of Health Insurance Studies. Furthermore, evaluative contracts are usually arranged with disinterested third parties—generally large private consulting organizations and universities—so that the evaluation will not be biased by prior involvement in the demonstration.

INCENTIVE REIMBURSEMENT

I would now like to highlight our research in the incentive reimbursement area—our first field of endeavor. Under the authority of section 402 of the Social Security Amendments of 1967 (Public Law 90–248), we have completed five incentive reimbursement experiments. Each of the experiments was designed to test a specific hypothesis relating to the containment of hospital costs through the imposition of positive or negative financial incentives. Hospitals whose costs

were low would be financially rewarded, and those with high costs would be penalized. Although not all of the experiments successfully bore out the tested hypothesis, we have none-the-less learned a great deal from each project.

The major finding of the evaluators has been that incentive reimbursement will not work on a voluntary basis. Results show that the hospitals participating in experiments under section 402(a) on a voluntary basis retained too much maneuverability within the programs. In fact, in several cases hospitals that were dissatisfied with arrangements under the experiment dropped out altogether. These experiments also indicated that incentive reimbursement does not effect cost containment when it is part of a retrospective payment system.

PROSPECTIVE REIMBURSEMENT

As you know, section 222(a) of the Social Security Amendments of 1972 (Public Law 92–603), authorized further hospital reimbursement research which was to differ from section 402 experimentation in several significant ways, Section 222 specifically authorizes prospective reimbursement experimentation which is to include risk factors—if the provider spends less than the prospectively determined rates, it will be rewarded; if its costs exceed the prospective rate, it will, to various degrees, have to absorb the loss.

Beginning in 1974, SSA has participated in a number of prospective reimbursement demonstration projects under section 222(a). Three projects, which will terminate during 1977 and 1978, are a budget review program administered by Blue Cross of Western Pennsylvania; a system in South Carolina which combines budget review, management engineering, and financial planning; and a program in Rhode Islad which establishes a Statewide "Maxicap" limitation on allowable increases in total hospital operating expenses.

Contracts were awarded to develop prospective reimbursement systems in Colorado, California, and at Yale University. These projects are now well underway. In addition, SSA is currently evaluating seven prospective reimbursement systems which were developed under non-Federal auspices by a wide variety of sponsors including Blue Cross plans, State governments, and hospital associations. Specifically, the evaluations are designed to examine the impact of prospectively determined reimbursement on hospital behavior, cost patterns, and quality of patient care. Based on preliminary findings, we can report that prospective reimbursement generally exerts a modest downward effect on hospital cost increases without sacrificing the quality of services rendered by the hospital.

Both section 222(b) of the 1972 amendments and the more recent National Health Planning and Resources Development Act of 1974 enable us to work with States having statutes authorizing rate-setting authority. The Department was given the authority to tie in experiments and demonstration projects in the prospective reimbursement area with State rate-setting mechanisms. Unlike the projects implemented under section 222(a), the section 222(b) rate-setting programs require mandatory participation of providers on a Statewide basis. Thus far, eight States have enacted the necessary legislation. Under this authority, we have decided to participate with the Maryland Health Services Cost Review Commission in its State rate-setting experiment. SSA is currently negotiating the details of the experiment with the Commission. We believe that the mandatory participation aspect of this project will contribute greatly to the success of the project.

LONG-TERM CARE

While research in hospital prospective reimbursement has received the most attention, SSA has funded Medicare research in other areas as specified under section 222(b). In the area of long-term care, we are directing a number of baseline studies to develop specific prospective reimbursement methodologies appropriate for nursing homes. Also, a most promising project in the long-term care area is the Utah Cost Improvement Program which we recently extended for another year. The Utah experiment, which is exclusively a reimbursement study, was designed to encourage more efficient and economical use of hospital facilities by enabling a hospital to use some of its otherwise vacant beds for long-term care patients. To accomplish this, SSA waived certain Medicare cost allocation and accounting requirements. The initial findings from the Utah project indicate that long-term care services can be provided at substantially less cost than previously thought, and that the methodology employed in the experiment can alleviate two problems prevalent in many rural communities: low occupancy rates in community hospitals and a shortage of long-term beds. Other States have re-

sponded to the success of the Utah project by expressing interest in implementing a similar experiment. SSA recently awarded contracts to the Texas Hospital Association and Blue Cross of Western Iowa and South Dakota to duplicate the Utah experiment in order to validate the results and to determine whether the success in Utah would occur in other geographic areas. Additionally, in the long-term care area, we are preparing to solicit proposals to develop specific prospective reimbursement methodologies for nursing homes, and to study the effects of waiving the 3-day prior-hospital-stay requirement for coverage of skilled nursing facility care.

PHYSICIAN REIMBURSEMENT AND OTHER NONINSTITUTIONAL PROVIDERS

We are also quite interested in pursuing research beyond the walls of institutional providers. In the area of physician reimbursement, for example, six projects have been initiated to study the effects of alternative fee-for-service methods on beneficiaries' out-of-pocket expenditures, on patterns of medical practice, and on physician incomes. We are most interested, of course, in developing a payment method which will encourage physicians to accept assignment and thus reduce the beneficiaries' expenses. In addition, an experimental design developed by Robert R. Nathan Associates, which would substitute a negotiated fee schedule for the present medicare reasonable charge arrangement, is presently being reviewed by various HEW components for possible implementation.

Research in other noninstitutional areas is authorized through the provision of section 222(B) which allows experimentation with reimbursement for those services not specifically reimbursable under present Medicare law. Areas where this research is underway or in the planning stage include a study of coverage of services rendered by independent clinical psychologists, expanded mental health coverage, and a project examining reimbursement for surgical care in outpatient facilities. This year's budget includes plans for a demonstration project in Colorado to determine the effects of covering clinical psychologists as independent practitioners, and the effect of raising the Medicare part B outpatient mental health care coverage limitation to $400 with 20-percent coinsurance. The purpose of the clinical psychology experiment is to determine if expanded mental health care coverage should be made available to Medicare beneficiaries. The cost effectiveness of reimbursement for ambulatory surgical care in facilities apart from hospitals is being tested under an arrangement with the Surgicenter of Phoneix and through five other centers around the country.

We are aware of the Subcommittee's interest in the experimental coverage of physician extender (PE) services. Presently, as you know, Medicare reimbursement for services performed by PE's is limited to services provided under the direct supervision of a physician. PE services are commonly rendered without specific charge or are included as part of the physician's bill. It has been maintained that coverage of PE services where there is no direct physician involvement would both lower program costs and improve the beneficiaries' access to medical care. We are now conducting a study to determine the cost effectiveness of several options for reimbursement for PE services.

During the first phase of this study, we are analyzing two groups of physician practices—those with physician extenders and those without—in an effort to determine the possible differences in practice productivity, organization, and patient population. The second phase of this study, which is already operational in five part B carrier areas, is experimentation with different methods of PE reimbursement. Eventually 30 of the 47 Medicare carriers will be reimbursing for PE services for up to 2 years. Our evaluation, after the 2 years of experimentation, will focus on the capacity of physician extenders to provide high-quality health care to Medicare beneficiaries at less cost than it can be provided under current law.

DURABLE MEDICAL EQUIPMENT

Now let me turn to another area of research in which this Subcommittee has expressed particular interest—Medicare reimbursement for durable medical equipment (DME). As you know, section 245 of the 1972 amendments authorizes reimbursement experiments designed to eliminate unreasonable expenses resulting from prolonged rental of durable medical equipment. We have financed through private contractors the design of three new reimbursement systems. These systems involve: (1) a prepayment plan under which beneficiaries would pay a fixed monthly amount for any necessary durable medical equipment; (2) a system which would automatically convert the durable medical equipment from

rental to ownership when the aggregate rental payment equaled the reasonable charge for purchase plus one month's rent; and (3) a system which would include a lump-sum payment for new and used equipment coupled with a rental-purchase conversion procedure. After careful analysis of these three system designs, we have determined that the third system is the most conducive to implementation at this time.

Thus, we are in the process of procuring a contract to conduct a 2- to 3-year experiment which would provide for reimbursement for durable medical equipment on a lump-sum basis whenever it is determined that a lump-sum payment would be more economical than the anticipated period of rental payment. The experiment would also include incentives to beneficiaries to purchase used equipment whenever the purchase price is at least 25 percent less than the reasonable charge for new equipment. We intend to evaluate this experiment to determine whether or not the new reimbursement system represents a less costly means of providing durable medical equipment and whether it affects the quality of the durable medical equipment or services provided to Medicare beneficiaries. It should be noted that DME experimentation will have limited results in terms of program payoff, since the total expenditures under part B for DME in the current year are expected to be only about $95 million.

Meanwhile, based on recent advice of our Office of the General Counsel, steps have been initiated within the Bureau of Health Insurance to implement section 245 of Public Law 92-603 to the extent feasible. Work is now being done (as a step in the development of new regulations) to identify the policy issues and technical problems involved in implementing section 245 and to determine alternatives for resolving them.

CONCLUSION

While we have encountered many problems along the way, we are confident that our expanding research programs will help to yield solid information which will assist policymakers in both the executive and legislative branches to knowledgeably address the broad issues of health care cost containment and improvements in the organization and delivery of health care.

This concludes my prepared remarks. My colleagues and I would be happy to respond to any questions you might have.

Mr. PICKLE. I see in your statement on page 9 of your testimony that, "based on preliminary findings," of studies underway, "we can report that prospective reimbursement generally exerts a modest downward effect on hospital cost increases without sacrificing the quality of services rendered by the hospital."

That would indicate to me that you are saying that this looks like it might be a good or better approach, that it does reduce the cost a little bit, and that it does not reduce the quality.

But you have just said previous to that that it doesn't have any effect on cost. Does it, or doesn't it?

Commissioner CARDWELL. No, sir. I said incentive reimbursement, which precedes the prospective reimbursement references in the statement showed us fairly conclusively that they will not function if we depend on them to be adopted voluntarily by the providers of services.

The remarks about early insights into prospective reimbursement need to be qualified very carefully. They have all taken place in a constrained, artificial environment. They have not functioned freely in what is a very free market system.

That would be an entirely different matter and we wouldn't want to conclude that they would function uniformly and effectively and at the same time restrain costs without interfering with some other values that this society has so far decided to preserve—a person's freedom to choose his physician.

Delivery choices on the part of the policymakers in the Government would not interfere in deciding the course of treatment. So far we have decided not to interfere in establishing the costs of or the billing

for such treatment. We have drawn some lines as to how much the Federal Government would reimburse, but we have not crossed over the line that says the Federal Government can effectively take on the role of literally prescribing what shall be charged for what service.

It would seem that is a very serious matter to contemplate.

Mr. PICKLE. I would like to know this. You may not be able, either you or the Secretary, to tell me now, but I would like to know under the programs mandated by the Medicare Act, as amended, how much have you spent on research and development between 1967 and 1972 and between 1972 and now?

I think that would be of interest to the Congress.

Commissioner CARDWELL. Between 1967 and 1972, something in excess of about $4.5 million was spent in direct costs for managing research and experimentation. Since that time, we have spent about $15 million. On prospective reimbursement our budget this year calls for spending about $5 million. We have 12 projects underway, and 5 that are nearing operating status.

Mr. PICKLE. One last thing, Mr. Cardwell. Did I understand you to say that you were not making any—or rather, did I understand you to say that from what little you knew about the facts as established on a cost-saving incentive program, it would be a questionable approach right now?

Commissioner CARDWELL. Yes. Based on basic cost incentive devices that we experimented with during the period 1968 to 1972 or 1973.

I wouldn't want to make that statement about prospective reimbursement. In fact, I think our judgment so far is that it offers a good prospect, but it is quite clear that prospect will always pose for the Congress some very tough future choices. I don't think you can have prospective reimbursement without probably inviting some forms of interference that do not now exist.

Mr. PICKLE. If you use the prospective reimbursement approach, for what length of time probably would you be locked into?

Commissioner CARDWELL. Let's divide that into two parts. Based on the experiments we are saying it is going to be 1978 or 1979 before we would have well-thought-through analyses that we could lay before the Congress, although I think we should commit ourselves to report to the Congress during the interim.

But once you make the public policy choice to use that system, it would become permanent and would not have self-limiting time features. I doubt that we could afford nationally to move to one system and then 2 or 3 years later move again to still another system.

It would probably be wise if we think this through very carefully and, once we make a move, go ahead and make it.

Mr. PICKLE. I believe you misunderstood my question. I wouldn't recommend to set up one system and say that it is going to be for 1 year or 2 years or forever——

Commissioner CARDWELL. I see.

Mr. PICKLE [continuing]. The period of the allocable costs that you base your reimbursement on.

Commissioner CARDWELL. I would like to ask others who are more knowledgeable to speak on it. My theory is that it should be a system that is constantly being updated, that rolls with experience, and that as experience and changing circumstances—the introduction of new

techniques, new approaches to practice, new modes of delivery—come into play the system would automatically adjust in anticipation of the effect of such change.

Any system has to be based on past experience, and it should keep a running account and should be self-adjusting as time moves. That would be my theory.

I think others here probably agree with me.

Mr. VANDER VEEN. I would like to see if the members of the panel agree with this statement.

First, there is agreement among us all as to the necessity of making a determination as to which agencies shall have the responsibility within HEW for the effectuating of section 222 and section 402.

Second, with reference to the line of questions by the gentleman from Texas and the responses by the Commissioner, while I don't think anyone would disagree with you, Commissioner—that is, no Member of Congress would disagree with your statement—as I understand it, it would not be desirable to launch off suddenly in the direction that you described. On the other hand, I think there is a feeling in Congress that something like $20 million has been expended here over this period of time and that no recommendations have been received from HEW.

Commissioner CARDWELL. I think that is a valid concern. Since I think the Social Security Administration has been involved in this whole process for longer and to a greater extent than the other elements of HEW, I think we should take the burden of that criticism. I think part of the criticism that we must absorb is our failure to feed back to the Congress on a timely basis the record and what we were and were not doing.

As I noted, we already have some conclusions on the cost incentive results that we probably would not have reported to you had it not been for this hearing.

Mr. VANDER VEEN. That is gratifying. I hope, if I might interrupt, as a further consequence of this hearing we can look for some further recommendations and the public can see something for their $20 million.

Commissioner CARDWELL. Could I make a comment on that point? I think we should here and now commit ourselves to some regular reporting back to the Congress as we pass various stages of the processes.

I would like to make quite clear, if I can, that you shouldn't expect in the propsective reimbursement area, for example, that the experiments themselves will necessarily produce a clear-cut answer.

Mr. VANDER VEEN. I don't think that I meant to.

Commissioner CARDWELL. My guess is that it will not.

Mr. VANDER VEEN. I don't think I meant to imply that. I hope it is somewhat clear, but I don't think I meant to imply that there would be answers which would be panaceas. We would like to know if something cannot be done as well as whether or not something can be done.

The main point, I think, that has been brought out today—if I may continue to interrupt—is that there are experiments which have been brought to the attention of HEW. People have tried valiantly over a long period of time to implement cost-saving ideas in the field of health care and have been bogged down for a great variety of reasons.

All we are asking, really, is that there be concerted effort within HEW and all of its agencies to do a more efficient job of effectuating these two sections.

Mrs. LYNCH. Mr. Chairman, I would like to comment on that.

Having spent 10 years in the State legislature, I am extremely aware of the kind of concern that Congress has in not getting timely reports from us.

I certainly told Mr. Cardwell and Dr. Cooper that I fully expect that we will do this. The Secretary feels just as strongly as I do. I would also like to point out to you that my experience has shown that both of these gentlemen have been extremely cooperative in trying to work with me.

I look forward to working with you and the committee in the next few months in trying to produce that kind of information for you.

Mr. VANDER VEEN. I appreciate that very much. I appreciate your statement also and the attitude of all of you and your cooperation. We will look forward very much to a quick resolution of these matters and to hearing from you soon.

I thank you all.

Dr. COOPER. Thank you.

Mrs. LYNCH. Thank you.

Commissioner CARDWELL. Thank you.

Mr. VANDER VEEN. This hearing will be adjourned.

[Whereupon, at 4:14 p.m. the hearing was adjourned.]

[The following was submitted for the record.]

[The following memoranda point out the serious problems that HEW had with delegation of responsibility for experimentation under section 222.]

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
March 19, 1976.

To: Associate Commissioner for Management and Administration.
From: Associate Commissioner for Program Policy and Planning.
Subject: Delegation of authority—sections 402(a) of the Social Security Amendments of 1967, as amended by section 222(b)(1) of the 1972 amendments; and section 222(a) of the Social Security Amendments of 1972—ACTION.

No formal delegations of authority have been made by the Secretary for implementation of any of the areas of experimentation specified in Section 402(a), as amended, or in Section 222. However, members of the staff of the Office of Administrative Appraisal and Planning (OAAP) have informed us that SSA has such authority via Section 1875(b) of title XVIII of the Social Security Act. Section 1875(b) reads:

"The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B (including a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by Section 226 of the Social Security Amendments of 1972, the experiments and demonstration projects authorized by Section 402 of the Social Security Amendments of 1967, and the experiments and demonstration projects authorized by Section 222(a) of the Social Security Amendments of 1972), and shall transmit to the Congress annually a report concerning the operation of such programs."

As the Commissioner has been delegated authority for the continuing administration of title XVIII, OAAP believes that a strong case exists for attaching that authority to Sections 402(a), as amended and 222 as well, due to their

specific mention in Section 1875(b). We agree that a case can be made for such an implication of authority. However, we are concerned (as is OGC) that legal problems can arise because of the lack of formal delegations.

We understand that OAAP has been preparing a package to the Secretary which will include a request that authority for implementation of Section 402 (a), as amended, and 222(a) be delegated to the Commissioner. This package is comprehensive and includes all statutes affecting SSA which have unclear lines of authority. Of course, it has taken a considerable amount of time to assure that all pertinent statutes are included and that necessary legal clearances have been obtained. We would suggest, therefore, that if the package is not going forward within 30 days, that delegation requests pertaining to Sections 402(a), as amended, and 222(a) be separated from the comprehensive package and sent forward to the Secretary.

The Commissioner has indicated his approval of preparing papers requesting that the Secretary delegate authority for implementing the provisions of Section 402(a), as amended, which pertain to clinical psychology experimentation (note attached concurrence from the Commissioner to our memo of December 23, 1975). We believe that this supports our request that steps be taken to obtain experimental authorities as soon as possible.

Please proceed with whatever steps must be taken to obtain a formal delegation of authority from the Secretary to the Commissioner for implementation of Section 402(a) of the 1967 Amendments, as amended by Section 222(b)(1) of the 1972 Amendments, and of Section 222(a) of the Social Security Amendments of 1972. The delegation papers going to the Secretary should specify that the Commissioner's authority may be redelegated. The Commissioner would then redelegate his authority to me, and I would in turn redelegate to the Assistant Commissioner for Research and Statistics. We would, of course, be glad to furnish any additional information you may need in forwarding this request.

ELMER W. SMITH.

Attachment: Tab A—Memorandum of December 28, 1975, OPPP to the Commissioner—Assignment of lead agency responsibility for clinical psychologists reimbursement experiment as authorized under section 222 of Public Law 92–603.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
December 23, 1975.

To: Mr. James B. Cardwell, Commissioner of Social Security.
From: Acting Associate Commissioner, Office of Program Policy and Planning.
Subject: Assignment of lead agency responsibility for clinical psychologists reimbursement exepriment as authorized under section 222 of Public Law 92–603—ACTION.

We concur with the December 12 memorandum from the Assistant Secretary for Health to the Commissioner assigning SSA lead responsibility for the Medicare clinical psychologist reimbursement experiment. This is appropriate because many of the operational aspects of the project are similar to the Physician Extender Study and the Medicare statistical system is essential for evaluating the experiment. Also, the Senate Finance Committee staff has strongly made their view known that SSA should be assigned responsibility, since little action has taken place in the three years following legislative enactment of the experimental provision. Without an experimental project in place soon, it is quite likely a full scale provision to reimburse clinical psychologists would be enacted. It is our belief that conducting a reimbursement experiment would shed considerable light on the merits and problems with a full scale provision, thus we have begun to plan an experiment.

We therefore recommend that you approve our proceeding to develop and implement an experiment; ask OMA to prepare the necessary delegation of authority papers to be sent to the Secretary; and that the experimental authority be redelegated to OPPP when approved by OS.

JOHN J. CARROLL.

Decision: Approved January 2, 1976.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH,
March 29, 1976.

To: Commissioner, Social Security Administration.
From: Assistant Secretary for Health.
Subject: Replies to Representatives Vanik and Vander Veen on DHEW health financing research: PHS/SSA relationships.

I have recently reviewed, personally and intensively, the problems we have been having on "Section 222" research. It is clear that in order for the Department to respond adequately to the repeated inquiries from Representative Vanik and to the most recent letter from Representative Vander Veen (Tab A), it will be necessary for us to resolve several issues of program definition and responsibility. In the best interest of the affected programs and the Department's overall mission, we need to clarify:

1. Current assignment of responsibilities.—The enclosed memo from then-Under Secretary Carlucci and the 1973 Implementation Plan (Tab B) represent the only official statements on assignments of responsibility for Section 222 research. I understand that there is a request for the full delegation to SSA of Section 222 authority under consideration within the SSA at this time. We need to clarify our lines of responsibility for this important area of research, and to resolve the delegation question before the Oversight Hearings on this subject before the Ways and Means Committee now scheduled for the last week in April.

2. Definition of "Section 222" Research.—Part of our past difficulties in health financing research appear to stem from too narrow a view of what "Section 222 research" encompasses. Section 222 of the Social Security Amendments of 1972 added important additional authority for the granting of waivers, and expanded the Department's authorities for the conduct of health financing research. In my view, a too narrow interpretation of "222" research has inhibited the Department's ability to impart to the Congress a full "understanding of DHEW research relevant to the purposes of Section 222." "Section 222" research is not just waiver research, but encompasses a wide range of health financing and health services research supported and conducted by many components of the Department. To restrict the reports to the Ways and Means Committee to "222" waiver research gives a distorted picture of the substance, objectives, and full extent of the Department's involvement and commitment in this important area of research. This narrow interpretation has also permitted the Congress to erroneously conclude that the Department has neglected research in the substantive areas of 222 research as is evidenced in the Vander Veen letter of March 22 (Tab A) and the March 22 Congressional Record statement by Oversight Committee Chairman Vani, Tab C).

3. Reimbursement for experimental intermediary costs.—Mr. De George has recently written to the Executive Officer of the PHS asking for assistance in resolving long-standing confusion and dispute about who should justify and pay the costs associated with the benefit-package experimentation funded by the National Center for Health Services Research. Mr. Moure has now responded to Mr. De George, making clear our firm view that the expertise gained through the design and implementation of these experimental reimbursement systems is critically important and should be maintained and developed within the Department. We have developed an extraordinarily good working relationship with the Division of Direct Reimbursement, Bureau of Health Insurance, through these experimental fiscal intermediary functions. I am distressed to hear that this excellent unit may be deactivated, as a consequence of this budetary dispute, since to disband this resource would effectively destroy our experiments. I continue to believe that the payment of the intermediary costs for the benefit-package experiments is an appropriate contribution of the SSA to these experiments in which the PHS and SSA have a strong mutual interest.

It is especially important for us to clarify these issues before the Oversight Hearings of the Ways and Means Committee. It also seemed important for me to express my perception of these issues in preparation for our discussion.

THEODORE COOPER, M.D.

[The following is a further example of the bureaucratic delays that plague HEW. Under section 109 of Public Law 94–182, a section regarding medicare reimbursement for services provided by optometrists, the Secretary of HEW was required to submit to Congress a report concerning the feasibility of reimbursement:

"STUDY REGARDING COVERAGE UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

"SEC. 109. The Secretary of Health, Education, and Welfare shall conduct a study of, and submit to the Congress not later than 4 months after the date of enactment of this section a report containing his findings and recommendations with respect to, the appropriateness of reimbursement under the insurance program established by part B of title XVIII of the Social Security Act for services performed by doctors of optometry but not presently recognized for purposes of reimbursement with respect to the provision of prosthetic lenses for patients with aphakia."

Public Law 94–182 was enacted on December 31, 1975, and required a report to the Congress "not later than four months" after its enactment (i.e., by April 30). The following letter, received by Cong. Vanik on July 16, shows that the report, already 2 months overdue, is still not finished:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., July 14, 1976.

HON. CHARLES A. VANIK,
Chairman, Subcommittee on Oversight,
Committee on Ways and Means,
Washington, D.C.

DEAR MR. VANIK: Commissioner of Social Security James Cardwell has asked me to reply to your letter of June 14, 1976, about the status of the Department's study regarding coverage under Part B of Medicare for certain services provided by optometrists. The Health Resources Administration of the Public Health Service has the primary responsibility for this study required by the Social Security Amendments Act of 1975 (P.L. 94–182). The Act also requires that we submit to the Congress a report containing our findings and recommendations based on the study.

A draft of the report is now being reviewed. We are attempting to conclude our deliberation as quickly as possible while giving thoughtful consideration to the impact of any recommendation on the quality and cost of health care. Thank you for your interest in the report.

Sincerely yours,

THEODORE COOPER, M.D.,
Assistant Secretary for Health.

NATIONAL COUNCIL OF HEALTH CARE SERVICES,
Washington, D.C., May 10, 1976.

SUBCOMMITTEE ON OVERSIGHT,
Committee on Ways and Means,
U.S. House of Representatives,
Washington, D.C.

DEAR SIR: In follow-up to our conversation regarding Section 222 of Public Law 92–603, I am sending with this letter copies of two projects which directly relate to the proposed RFP which SSA will issue "in the spring of 1976" for prospective reimbursement in long term care.

You may recall that I mentioned the needless duplication of government contracts which are awarded and I feel this is another example of just that. While HEW is talking about a new RFP on costs of services in long term care, rates of return, and case studies in their letter to your Subcommittee, much of this work has already been or is well underway towards completion, as evidenced by the attached papers from Applied Management Sciences and the Urban Institute.

It would be nice if HEW could get its act together, and I know that is one of the things the Subcommittee on Oversight is trying to bring about.

Please let us know if we can be of an assistance to you or to your Subcommittee.

Yours very truly,

DONNA R. BARNAKO.

[Abstract of study undertaken for HEW (Office of Secretary) begun last September by Urban Institute, Washington, D.C.]

Nursing Home Supply and Utilization, 1964–74

The objective of this study is to develop a thorough understanding of the determinants and patterns of growth of the nursing home and related facility industry between 1964 and 1974. Although the fact of rapid growth in the supply and use of nursing homes is widely recognized, aspects of that growth often are ignored. Growth rates, for example, were not uniform but varied widely among states. Thus between 1960 and 1973, six states experienced annual growth rates higher than 12 percent and six others experienced growth rates lower than 5 percent. Second, growth did not proceed evenly but occurred at widely varying rates over the period.

It also is widely assumed that nursing home supply increases were stimulated primarily by the Medicaid and Medicare programs. This view, however, both fails to explain rapid increases prior to implementation of those programs and neglects other changes whose influence may have exceeded that of new medical finance programs. These include the proportion of the elderly who are very old, the declining use of mental hospitals, the increased participation of women in the labor force, rising incomes and so on.

This study will analyze variations across time and place in nursing home growth and utilization in an effort to understand how program, demographic, economic, and social forces interacted in stimulating the nursing home industry. Additionally, it will attempt to identify the roles played by program characteristics (reimbursement policy, eligibility standards, direct controls, etc.) as well as by market forces such as occupancy rates. It will focus, moreover, not only on overall growth but also on the distribution of increases between different levels of care and types of facility ownership.

The project will review existing writings in the area, will collect and assemble quantitative and qualitative data, and will use both informal analysis and formal quantitative techniques to interpret the collected data. A substantial proportion of the total project effort, however, will be devoted to the collecion of information and data from twelve states. This is necessitated by two considerations. First, only sparse data are available nationally on several of the quantitative dependent and independent variables in which we are interested. Second, it is impossible to identify from published sources most of the major and minor details of state policy which may have impacted on the rate and pattern of nursing home growth. Through visits to the states involving conversations with present and former officials, we plan both to develop chronologies of state policies and to accumulate insights and analysis concerning the effects of those policies on the course of the nursing home industry. Information thus developed will be one of the primary bases for our informal analyses of growth trends and will assist in the formulation of hypotheses for more formal quantitative testing.

The project is funded by an H.E.W. contract. It will last eighteen months and will produce a final report of its findings in April, 1977.

Report on Systems of Reimbursement for Long-Term Care (LTC) Services [1]

Executive Summary

INTRODUCTION

The nursing home industry is clearly becoming a major component within the health care delivery system. Over the last two decades the volume of service as well as the expenditures for long-term care have risen dramatically, both in absolute terms and in relation to the acute-care hospital sector. Given the substantial growth in the LTC industry, the need to study existing reimbursement systems is increased by the realization that almost 60 percent of LTC expenditures is made from public funds.

The Medicaid program is administered by the Social and Rehabilitation Service of DHEW, and it is incumbent on SRS to develop criteria to help ensure the efficient administration of the program and to review states' implementation of the

[1] Prepared by Applied Management Services for National Center for Health Services Research, Health Resources Administration, Department of Health, Education, and Welfare, April 7, 1976, in fulfillment of contract No. HRA 106–74–186.

prescribed criteria. This responsibility is particularly important this year in light of Section 249 of P.L. 92–603, which prescribes that payment for services to skilled and intermediate care facilities under the Medicaid program must be made on a reasonable cost-related basis, effective July 1, 1976. Applied Management Sciences has found that nine states had flat-rate systems as of January, 1975.

The purpose of this project was to review the LTC reimbursement systems currently in use as well as systems that have been proposed by states or independent researchers in an effort to identify those systems or features of systems which best facilitate the achievement of objectives related to public, institutional reimbursement. The study included the conduct of three state-level conferences and one national conference on critical issues in LTC reimbursement. The state conferences focused on the Medicaid reimbursement systems of Colorado, New York, Illinois and Minnesota.

Volume I of the Final Report consists of analysis of seven general issues which must be addressed in the development of a reimbursement system. The issues, each of which is incorporated into a chapter of the report, are as follows: Prospective and retroactive payment; Units of payment; Cost of capital; Profit; Allowable costs; Cost reporting and auditing requirements; and Cost, performance, and quality standards.

Within each chapter, a quantitative summary of applicable state practices is presented, followed by an analysis of the impact of each major alternative on the quality, cost, and accessibility of long-term care services. The appropriateness and acceptability of each alternative is then discussed from both the state and Federal perspective. When indicated, the alternatives are ranked including a recommendation as to the optimal approach. There are an infinite number of reimbursement systems that could evolve from combinations of features discussed in the report. The usefulness of the analysis is intended to stem from the need to evaluate specific features of reimbursement systems that might be proposed, rather than to recommend the model, complete system.

Volume II of the Final Report contains the proceedings of conferences on long-term care reimbursement, including the seven papers prepared for delivery at the national conference. Volume III is a compilation of background materials developed for the study, including a comprehensive bibliography, a summary of the results of a nationwide survey on reimbursement issues, and individual synopsies of the state Medicaid reimbursement systems.

The remainder of this document consists of a summary of Applied Management Sciences' recommendations pertaining to the major issues listed above.

ANALYSIS AND RECOMMENDATIONS

Prospective versus retroactive payment

Rates have traditionally been established retroactively; that is, based on actual costs incurred during a period. Prospective reimbursement provides for establishment of a payment rate prior to a period, with a penalty for operation above the prescribed rate and an incentive payment for operation significantly below the target rate. Prospective payment is endorsed because it introduces a strong incentive for cost containment, allows the fiscal agent an element of control over the industry norm for inflation in cost, and encourages the development of budgeting and control procedures by providers.

Several issues of system for prospective reimbursement have been addressed.

1. Voluntary participation for providers is discouraged as inconsistent with the objective of cost control.

2. Detailed review of prospective budgets is recommended only for proposed changes in facilities and services which significantly change the cost base on which a rate of inflation is predicted.

3. A minimum level of cost categorization is needed to assure accuracy of prediction. An appropriate model would be prediction based on separate economic indicators (e.g., wholesale price indices) for the following: Salaries and fringe benefits; non-labor expenses—administrative and general; household and maintenance; dietary, and professional care.

4. Retroactive adjustment of the payment rate should be allowed only on an exception basis, with criteria published listing the unusual circumstances for which an appeal will be considered.

5. A system should involve both penalty and bonus payments, although sharing of the penalty/bonus between the fiscal agent and individual facilities is an appropriate local option.

Units of payment

Three issues are discussed in this chapter, each of which must be considered separately in the design of a reimbursement system.

First, calculation of reimbursement rates based on groups of facilities rather than individual facilities is advocated. In a retroactive system, this approach provides an otherwise lacking incentive for cost containment. The grouping of facilities should be based on cost-influencing variables which are not within the control of providers in the short run. The most effective of such variables are bed size and factor prices (e.g., a wage index) though patient mix and ownership (i.e., governmental versus nongovernmental) are also applicable. The best use of group averages is to establish maximum limits on cost elements, rather than to use the group average itself as the reimbursement rate.

The second decision involves facility versus patient-specific reimbursement rates. Several states have adopted point systems that measure patients needs (e.g., incontinency, tube-feeding) as the basis of patient-specific reimbursement, and this has the important advantage of discouraging discrimination against potentially high-debility patients. However, relating the approach to actual cost is difficult, current systems are costly to administer, and the potential exists for providers to overclassify patients in order to maximize reimbursement. Patient-specific reimbursement should be avoided until models being developed (including one by Applied Management Sciences) have been thoroughly tested.

Alternative units of payment that have been proposed for LTC reimbursement are case, person (capitation), specific services, and total budget. While these approaches have definite applicability to other sectors (e.g., HMOs, acute-care hospitals), the traditional patient day is recommended for long-term care.

Cost of capital

In order to maintain the existing level of investment in the long-term care industry, reimbursement must be made for the economic cost (or opportunity cost) of owner's capital. The total cost of capital, and hence total income received by the owners of capital, is the sum of interest net of capital gains (and losses) and depreciation expenses. It is essential that the effect of a mechanism to manipulate one of these cost elements not be considered in isolation of its impact on the other two and, hence, the total cost of capital.

A measure of current value of assets is important in determining the cost of capital. It is strongly recommended that sale values of assets not be used to estimate current values for capital reimbursement, as this introduces an incentive for buyers to pay inflated prices for nursing homes. An alternative is to use the original cost inflated by a price index.

There are three alternative approaches that can be used in determining depreciation payments; historical cost depreciation, replacement cost depreciation, and an allowance in lieu of actual depreciation. The historical approach has further options of straight-line and accelerated calculation, which determine the rapidity with which book value is reduced. Both of these options are clearly acceptable, although the accelerated method has the advantages of assuring adequate funds to meet debt obligations and providing a hedge against the impact of inflation and technological advances.

Certain replacement value approaches for depreciation payment (including a method of adjusting current value payment for the age of a facility) are considered viable alternatives. If sale values are not used to estimate current value, this approach will reduce the problem of rapid turnover of ownership of nursing homes.

Payment of a percentage of costs in lieu of actual depreciation is not recommended for all facilities. However, states may wish to offer this approach as an option, which would serve to subsidize older facilities. The similar approach of substituting an imputed rental value for actual depreciation may be a viable approach, depending on the accuracy of rental value estimates. This method would also reduce the incentive to sell facilities at inflated prices, as rental value is not affected by a sale.

Funded depreciation (i.e., placement of depreciation payments in a separate fund to be used only for asset replacement) should be encouraged as a desirable internal management technique. However, there is no reason to require such funding as a condition of reimbursement.

Reimbursement for cost of capital must include interest payments for both equity and debt capital. In the case of debt capital, an interest standard can be based on the rate for relatively risk-free investments (e.g., mortgages) in

LTC industry. The interest rate (or net return) for equity should be based on comparison with other industries, with risk equivalency as the primary criterion of comparison. Applicable techniques for comparing rates of return in terms of risk are the book rate of return and the capital asset pricing model. Clearly, this is an area where additional research would be beneficial.

With respect to capital gains, an important issue has been the rapid turnover of nursing home ownership. A method to combat this problem is to retain original book value for capital reimbursement upon sale, thereby eliminating the expectation of capital gains. While this is an acceptable policy, the equity interest rate must be raised when it is implemented in order to assure that total capital cost reimbursement equates with opportunity cost.

Capital is equally productive regardless of whether assets are leased or owned, and as such, reimbursement should not vary with form of ownership. Lease cost implicitly involves valuation of assets at current cost, and if full lease cost is reimbursed, depreciation payments must also be based on current value of assets.

Profit

Profit should be considered the residual income received by capital owners, in that it is the difference between total revenue and total cost when the latter includes interest payments on equity capital. If profit is to be allowed, it should be determined as a return on equity. Payment of profit as a percentage of operating cost or as an amount per patient day is not recommended, as these approaches introduce an incentive to increase cost and/or patient days in order to maximize return on investment. Determination of the amount or rate of profit should be based on the growth-related objectives of state policy. A payment of any profit above opportunity cost would in most cases result in expansion of the industry. Due to the complexity of the profit and cost of capital issues, the use of expert consultants to determine the appropriate rate of profit to meet stated objectives is highly recommended.

Allowable costs

In addition to allowances for the cost of capital and profit, a Medicaid reimbursement system must provide for payment of other costs that are reasonable and necessary to the delivery of patient care. Recommendations with respect to key cost elements are as follows:

1. Charity and courtesy allowances, defined as reductions in charges made to indigent patients, and specialty groups (e.g., physicians, clergy), should not be provided for because they are not applicable to program beneficiaries.

2. Similarly, bad debts should not be allowed because they cannot be incurred on behalf of Medicaid patients since the program pays the full cost of services to its beneficiaries.

3. Net educational cost for programs meeting defined criteria (e.g., licensing and accreditation) should be an allowable expense, although it would be appropriate to place a limit on the allowance according to bed size.

4. Services of non-paid workers should be allowed if they hold full-time positions normally occupied by paid personnel and are members of organizations agreeing to work for no compensation. The amount to be paid can be determined from the average salary cost of other facilities as shown on annual cost reports.

5. It is imperative that standard definitions and guidelines be developed by each state for expenses to be reimbursed as "routine patient care" services. It is recommended that such services be reimbursed on an all-inclusive basis by Medicaid, rather than through more than one state program.

6. Purchase discounts (cash, trade, and quantity discounts) are reductions in the provider's costs, and as such should result in corresponding reductions in reimbursement.

7. Costs to related organizations (i.e., one that owns or controls the provider, or is owned or controlled by the provider) should be allowed, provided these costs do not exceed the price for comparable services in the market place.

Cost reporting and auditing requirements

A provision for cost reporting and auditing is essential in a cost-related system of reimbursement. The system should be designed (1) to attest the accuracy of financial data and identify financial manipulation, (2) to provide for the determination of reimbursement standards and payment rates, and (3) to provide information for analysis of overall cost and the cost/benefit of government programs. Cost reports should be required on an annual basis to assure availability of current data for both reimbursement and evaluation purposes.

Varying levels of cost and statistical data are required for different reimbursement systems. However, a minimum level of display of costs by cost center is recommended under any system. While differential reporting requirements by size of facility is appropriate, it is essential that sub-categories "collapse" into comparable totals for all facilities.

To enhance the accuracy of cost data for comparative purposes, implementation of a uniform chart of accounts at the state level is highly recommended. While implementation of the system may be costly, the system will probably justify itself in the long run through reduction in administrative costs for both the fiscal agent and individual facilities. The need for monitoring of industry trends and analysis of the impact of programs and standards also suggests consideration of a uniform chart of accounts and minimum reporting requirements at the Federal level.

While an auditing program is essential, a requirement for a comprehensive field audit of all participating facilities on an annual basis would be prohibitively expensive. It is recommended that the state audit program be administered as follows:

1. A complete field audit required of all facilities requesting to participate in the Medicaid program for the first time.
2. Desk audits performed annually for all participating institutions.
3. Field audits performed automatically when discrepancies or questionable accounting procedures are discovered during a desk audit.
4. Complete field audits performed for all participating facilities on an average of every four to five years.

Cost, performance, and quality standards

Implicit in the development of operating standards for LTC facilities is the use of these standards as incentives, penalties, or both. Several of the standards discussed are applicable only to retroactive reimbursement and are intended to counter the lack of incentive for cost containment inherent in this approach.

Total cost is recommended as the best quantity for application of cost maximums. The most common approach for determining maximums is a percentage above the mean or median cost of facilities grouped according to the variables discussed in Chapter 3. The use of median rather than mean costs is recommended in order to avoid the influence of extreme values. A promising alternative approach is to calculate maximums through use of a regression model, whereby the same variables that are applicable for grouping are used to "predict" cost standards on a facility-specific basis. Applied Management Sciences is involved in two projects to develop such an approach for both hospitals and long-term care facilities. It is recommended that a bonus payment be made for operating significantly below a reasonable cost standard, in addition to use of the standard as a maximum.

A maximum limit on the compensation of owner/administrators and their relatives is recommended for the purpose of eliminating the possibility that owners may pay themselves or relatives excessive salaries for services rendered in order to increase their return on investment. Determination of the maximum should be made by comparison to the salaries of administrators who are not owners. States may wish to establish minimum salary levels for administrators in order to attract competent individuals, although such limits should be used in conjunction with certification or educational requirements. All salary standards should be based on the bed size of facilities.

Quantitative limits on interest rates for debt capital are discouraged because of the wide fluctuation of rates over time and among borrowers. The only limitation should be that loans satisfy a need related to patient care and be incurred at a rate not in excess of what a "prudent borrower" would pay in an arms-length transaction.

Limits on the amount of depreciation payment (per bed) can be imposed in order to prevent the public funding of lavish facilities. However, defining the optimum level requires extensive and continual analysis. The objective of such a limit can be accomplished more effectively through use of a limit on total cost. A limit on total cost is also superior to placing maximums on individual cost centers such as nursing service, maintenance and household expenses, etc.

The most effective performance standard for a Medicaid reimbursement system is an occupancy level requirement. A minimum occupancy standard (i.e., per diem calculated by the number of days implied by operation at the standard occupancy, rather than actual days) can serve to discourage construction in

localities where utilization is presently low. A maximum occupancy standard (i.e., a bonus payment for operating above a prescribed level) can be used to either encourage or discourage expansion of the bed supply, depending on the average occupancy in a given locale relative to the standard which is set. Subject to the viability of planning at the state level, use of both a minimum and maximum occupancy standard is recommended. The actual point of an occupancy standard should be based solely on supply-related criteria. Minimum occupancy standards should be lower for new facilities for a period of up to three years.

Minimum limits on nursing staff time (i.e., man hours per patient) are recommended as encouraging an adequate quality of care. However, maximum standards for staff time are less desirable than limits on total cost as a cost-containment tool.

Penalties for the late submission of cost reports are advocated, although the amount of a penalty should be reasonable to increase the probability that it will be applied without hesitation.

A penalty provision for failure to comply with quality-related standards such as certification or licensure requirements is also an appropriate feature of a reimbursement system. However, because a significant percentage of LTC facilities presently cannot meet applicable standards, the goal of this provision should be modification of facilities to achieve compliance. As such, a reduction in payment should be large enough to impact on the facility, but not large enough to financially ruin the facility or force it to withdraw from the Medicaid program. The development of quality assessment techniques and a provision to tie such programs to the reimbursement system is also recommended.

Project Description—Expanded Medicare Benefits Project (222 Project) in San Francisco, Calif.

I. Introduction

The Expanded Medicare Benefits Project (222 Project) was authorized under Section 222 of H.R. 1—Public Law 92-603, the Social Security Amendments of 1972. Requests for Proposals to undertake a demonstration Project for Homemaker Services and/or Day Health (Adult Day Care) Services were released in the early Spring of 1974. San Francisco Home Health Service and the Visiting Nurse Association of San Francisco, Inc., worked together to develop a Response to the Request for Proposal. This resulted in a contract being awarded to San Francisco Home Health Service in June of 1974, to undertake a demonstration Project in Homemaker and Day Health (Adult Day Care) Services with the Visiting Nurse Association of San Francisco, Inc., acting as the Assisting Agency by providing administrative and service staff assistance to the Project.

The purpose of the Expanded Medicare Benefits Project is to test the patient outcome and cost effectiveness of Homemaker Service and/or Day Health (Adult Day Care) Services provided to a population of Medicare eligible persons. Six other sites in the country were awarded contracts for demonstration Projects to provide either Homemaker Service or Day Health (Adult Day Care) Services with one other site providing both of the services.

Other Projects are at:

(1) St. Camillus Skilled Nursing Facility, Syracuse, N.Y.
(2) Burke Rehabilitation Hospital, White Plains, N.Y.
(3) Inner-city Home Health Agency, Los Angeles, Calif.
(4) Homemaker Home Health Service of Providence, R.I.
(5) Lexington Fayette County Health Department, Lexington, Ky.
(6) Albert Einstein Medical Center, New York, N.Y.

The data obtained from patient assessment and service demonstration at each of these sites will be evaluated by a central Evaluation Contractor, Medicus Systems, Inc. in Chicago, to determine

(*a*) What is the effect of the provision of Homemaker Service?
(*b*) What is the effect of the provision of Day Health Service?
(*c*) What is the effect of the provision of a combination of Homemaker Service and Day Health Services?
(*d*) What is the cost of providing the above services, and will this offset other costs; and
(*e*) What effect does provision of these services have on the utilization of the existing Medicare benefits? (Hospital, Skilled Nursing Facility, and Home Health Agency).

From this data, certain recommendations will be made regarding whether these services are effective, in terms of patient outcome and cost, and whether either or both of these levels of care should become part of the existing Medicare benefit package.

II. ELIGIBILITY REQUIREMENTS

Under the demonstration, Homemaker Services are provided as a post-hospital Part A Medicare Benefit and Day Health (Adult Day Care) Services are provided as a Part B Medicare benefit with no previous hospital stay requirement. The San Francisco Project is limited to Medicare eligible persons residing in San Francisco.

III. REFERRALS

The project was originally scheduled to begin accepting patient referrals on January 1, 1975, however, due to the need to obtain a variety of clearances from various components of Federal Government, including the Office of Management and Budget, the Project was delayed and did not begin until May 1, 1975. Originally, a six-month intake period scheduled to end on October 31, 1975, was planned, however, in order to obtain an adequate sample size at each of the sites, the intake period was extended through March 31, 1976. The delay in the implementation of the Project proved to be of assistance in that between November 1974 and May 1975, staff time was available to begin a program of Community Education regarding the project with presentation of the Project being made to groups such as the local Medical Society, a number of hospital administrators, nursing staffs and medical staffs, senior citizens groups, groups of professionals interested in the elderly, the local Health Department, and Department of Social Services, etc. Within this group of potential referral sources were a number of Hospital Discharge Planners employed by the Visiting Nurse Association of San Francisco, Inc., working under a contractual arrangement with several private hospitals in San Francisco who were well prepared for implementation of the Project. All of these sources resulted in a considerable payoff for the Project, in terms of referrals with the result that from May 1, 1975 through March 31, 1976, 1374 persons were referred to the Project. The Project currently is scheduled to end on December 31, 1976.

Early in the project, the need for a professional intake worker was established in that a number of patients were being referred for Homemaker Services and/or Day Health Services, often requiring another level of care, such as Home Health Agency skilled services, or Skilled Nursing Facility services. The position of intake worker was subsequently filled by an experienced Public Health Nurse who could screen referrals at the point of in take and determine whether the referral information indicated that the patient could be cared for by Homemaker Services, Day Health Services, or a combination of these two services, or by either or both of these services in combination with the traditional Home Health Agency Services.

IV. THE ASSESSMENT PROCESS

Following acceptance of the referral, the referral information was relayed to the interdisciplinary Assessment Team of the Project. The Assessment Team is composed of three Public Health Nurses, three Medical Social Workers, two part-time Physicians, a Physical Therapist, an Occupational Therapist, and a Public Health Nutritionist. One or more disciplines are responsible for the assessment of the patient. One member of the Team visited the patient in the hospital, the Skilled Nursing Facility or the home, and assessed the patient, using a standardized Assessment Tool. The Assessment Tool was developed by Dr. Sydney Katz and others of the University of Michigan, School of Public Health. Using this Tool, the Team was able to quantify patient proficiency along such parameters as activities of daily living, social contacts, range of motion, bed disability days, behaviour and orientation, perceptual ability, etc. This assessment information is coded for electronic data processing so that the functional status of the patient at the point of entry into the demonstration can be compared to the population at each site and between sites, can be compared between patients who receive services, and those who do not, and can be compared for individual patient change(s) over time. Any patient determined to be suitable for the demonstration, in that he or she could safely be managed and assisted by the Project services were accepted into the demonstration for a period of one year and with the intent of quarterly reassessment during their period of participation.

Following the assessment, the interviewing Team member conferences the case with two other Team members, preferably of different disciplines and develops an ideal care plan for each patient. The ideal care plan is developed on the premise that any services required by the patient are available. This is a data collection process to determine what services might be requested if all needed services could be available. Following the completion of this ideal treatment plan, the patient's record is then given to a clerk who randomly places the patient into either the test group referred to as The Expanded Medicare Benefits Group or into the Control Group, depending upon the patient's eligibility (post-hospital, non-post-hospital, Part A or Part B Medicare eligible). A patient in the Expanded Benefits group may receive one year's coverage for Homemaker Services, Day Health (Adult Day Care) Services or both of these levels of care. The Assessment Team refers the Expanded Benefits group patients to the Homemaker Services provider and/or to the Day Health Services provider, and refers the Control Group patient back to the Referral Source, usually a Hospital Discharge Planner or Hospital Social Worker, who then plans for the patient given the non-availability of the Project services.

Control Group patients, while retaining all of the existing traditional Medicare benefits, qualify for neither of the Expanded Benefits. Both groups of patients, Expanded Group and Control Group are reassessed at three-month intervals for a period of one year to determine the effect of the services.

V. PROJECT SERVICES

A. Homemaker services

The Homemaker Services benefit of the Project include professionally trained and supervised Homemakers who may provide services to a patient in his residence for as few as two to three hours per week or as much as forty hours per week. Over 200 patients have received the Homemaker Service benefit of the Project. Some receive this benefit in conjunction with Home Health Agency skilled nursing or therapy services, and some receive the benefit in conjunction with Day Health (Adult Day Care) Services. Since all of the Homemaker patients must be Part A eligible and are post-hospital, they are often in a post-acute phase of illness and may require more services than, for example, the usual Homemaker Services patient or the person eligible for the Attendant Care Program financed through the Department of Social Services. The Project Homemaker Services patients are more similar to the Part A Home Health Agency service patient, but often lack a medically defined need for skilled services which are considered "custodial" under present Medicare regulations.

B. Day health services or adult day care

At the onset of the Project, Adult Day Care was the term applied to what is now referred to as Day Health Services. The intent of these services is to provide a broad range of nursing, social work, rehabilitative services, recreational services, transportation and meals, to a group of patients in a day-time setting in order to prevent and postpone unnecessary utilization of in-patient facilities. Day Health Services differ from social model Day Care Programs, psychiatric Day Care programs and Senior Citizens Centers in that they provide services geared to treat physical illnesses as well as the depression and social isolation which often accompany illness. In San Francisco, Day Health Services funded by the Expanded Medicare Benefits Project are provided by three hospital-based providers:

(1) Ralph K. Davies Medical Center;
(2) Garden Hospital Jerd-Sullivan Rehabilitation Center;
(3) Mt. Zion Hospital and Medical Center.

Proposed rules under which the services are provided were published in the Federal Register, January 6, 1976. Under these rules, programs must offer services:

(*a*) which are provided under health leadership in an ambulatory care setting to adults who do not require 24 hour institutional care, but who are incapable of full-time independent living due to physical or mental impairment; and

(*b*) to adults who are referred to the program by their attending physician or by some other sources, and

(*c*) which satisfy the participant's health maintenance and restoration needs, including socialization elements to overcome isolation often associated with illness in the aged and disabled.

At the present, the programs include individuals who range from 36 to 96 years of age. A profile of an average person referred to Day Health Services would be a 75 year old female with multiple diagnosis including a primary diagnosis of cardiovascular disease. Program directors have described two general groups of individuals who benefit from the program:

(1) Those persons who have a physical disability and wish to reduce the disability, and

(2) Those persons isolated, due to being disabled and wish to reduce the isolation. The programs operate 5 days a week.

The average attendance per week per person is 2.5 or about 10 to 12 visits per month. While all patients receive group rehabilitative therapies, participants may be authorized to receive individual physical, occupational and speech therapies. Also eye and hearing examinations can be authorized in order to increase a person's participation in the activities.

The Project guidelines permit flexibility in staffing. At present, the Centers employ individuals who have access to consultants in the fields of medicine, psychiatry, social and physical therapy, occupational therapy, speech therapy, recreation therapy, nursing and allied health professions. Each Center daily records staff hours by task, in order to gather planning data to develop staffing pattern guidelines.

Each Center is affiliated with health training institutions and provides opportunities for on-the-job field placement for students.

VI. PROJECT OUTCOME

The Demonstration funds for the expanded Medicare Benefits Project are scheduled to cease on December 31, 1976. Over 1000 persons will have been participants in the Project and over 500 persons will have received Homemaker Services, Day Health Services or a combination of these two levels of care. Data on the outcomes of the participants, the services received the costs of these services and so on, will be compiled and forwarded to the Department of Health, Education and Welfare. A report of the demonstrations will, in turn, be submitted to Congress for consideration of these benefits in any proposed National Health Insurance program or in amending the current Medicare program.

VII. ADDITIONAL INFORMATION

Since Day Health Services are a relatively new level of care, little has been written to describe these services. Attached is a list of available references describing various programs in the United States and abroad.

THE EXPANDED MEDICARE BENEFITS PROJECT (222 PROJECT) [1] PRESENTED TO THE CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME, APRIL 9, 1976

(By Joyce A. Tufts, MPH, Project Coordinator)

D. Other data sources

Cost information for both Homemaker and Day Health Services will be available as well as actual utilization information. All of this data should assist in:

(1) Defining the Homemaker Service and/or Day Health Service benefit, the parameters of these services, the necessary components of services, such as supervision and other provider responsibilities;

(2) Developing standards for these services, i.e. what components must be included for safe and effective non-institutional care; by the active participation of providers with government.

(3) Defining patient assessment and the critical parameters of patient function that define service needs.

III. PROJECT OUTCOME INFORMATION TO DATE

The sample was completed on March 31, 1976, with over 950 patients admitted from a total of 1374 referrals. Early analysis of the data show some emerging patterns.

A. The service needs of these patients seem to be falling into three service categories in an equal distribution:

(1) Those who require only Homemaker Service;

[1] Edited by Oversight Subcommittee staff.

(2) Those who require only Day Health Service;
(3) Those who require both the Homemaker Services and Day Health Service.

Within these subsamples, a "20 percent shift phenomena" appears to be occurring wherein 20 percent of the population has moved from one Service category to another in a seven-month service period.

B. The professionally perceived need for services exceeds the patient demand particularly for the Day Health Service benefit, i.e. around 70% of the patients eligible for Homemaker Services use the service while only 40% to 50% of those eligible for Day Health Services actually use the benefit.

C. Average utilization of the Homemaker Service benefit is between 25 to 30 hours per month, and average Day Health Service utilization is around 2.5 days per week or 10 to 12 days per month.

IV. QUESTIONS ARISING FROM THE DEMONSTRATION

Perhaps the most valuable part of a demonstration is not to answer questions as much as to develop precise questions which need precise answers. The following questions have occurred to us in our experience with the Project and remain unanswered.

A. Are Homemaker Services and Day Health Services a form of geriatric care, or should they be non-institutional and/or ambulatory health care programs for all age groups who need the service?

B. Are these services Health Services or Social Services? If they are Health Services, are they also Mental Health Services?

C. Are these services rehabilitative or maintenance services? Can they be both?

While we would answer "all of these" to the above, we must be cautious of the mutually exclusive and fragmented bureaucracies that control the funding of health and social services.

If Homemaker Service and Day Health Services become funded Medicare benefits in the Health sector, might we not eventually fall prey to the same medically oriented restrictions that have been placed on Home Health Agency services. Or, on the other extreme, if we assert these are social services, might we not dilute them and prevent the occurrence of needed physical health interventions? Perhaps the most dangerous proposal would be to assert that these are also mental health services since the range of available services might be limited and they may be less attractive to a population who insists that it is mentally healthy. The question remains, who *should* fund and control these services?

Other questions relate to the services themselves:

A. What kinds of organizations and, in what settings should these services be based? For example, should a Day Health Center be hospital-based, skilled nursing facility based, Home Health Agency based, free-standing etc.?

B. What mechanisms need to be created to assure proper coordination of non-institutional services?

C. What impact will these services have on the utilization of other services, for example, does the provision of Day Health Service or Homemaker Service impinge on the territory of the Home Health Agency? Who will determine where the patient should be in this three faceted non-institutional care arena?

D. Finally, who will assume the responsibility for monitoring these services?

If tomorrow Day Health Services and Homemaker Services were to become funded Medicare benefits, we may well have created a monster capable of greater abuse and misuse of public funds than ever approached in the areas of Nursing Homes or Home Health Agencies.

Licensing and certification of providers must be required, standards for both levels of care must be developed and enforced, plans for coordination among these three levels of non-institutional care must be developed and followed, and must be further coordinated with institutional services.

We are convinced the Homemaker Services and Day Health Services are valuable additions to the range of community health services and should be made available. We hope to develop a data base which will support the value of these services. However, we are convinced that any legislation authorizing these services must include appropriate and clear definitions of the services while allowing enough flexibility for various styles of delivery; and, objective, enforceable (and enforced) standards that will prevent the abuse of these services by unqualified providers so that the retroactive, unrealistic application of regulations that has occurred in the Medicare program will not be repeated.

ADULT DAY HEALTH SERVICE REFERENCES

A Planning Study of Services to Non-Institutionalized Older Persons in Minnesota, the Governor's Citizens Council on Aging, State of Minnesota, 1974, prepared by the School of Public Affairs, University of Minnesota, Minneapolis, Minnesota. 55455. A comprehensive presentation of the programs for in-home health services.

A Study of the Administration of State Health Programs, January, 1976, by the Commission on California State Government Organization and Economy. Available through the Commission's office 11th and "L" Building, Suite 550, Sacramento, California. 95814.

Adult Day Care in the U.S. A Comparative Study prepared by Transcentury Corporation, 1789 Columbia Road, N.W., Washington, D.C. 20009. A comparative analysis of ten programs.

Doherty, Nevill J. G., Ph.D., "The Use of Cost Effectiveness Analysis in Geriatric Day Care", *The Gerontologist*, October, 1975. Pages 412–417. *Federal Register*, January 9, 1976. Day Care Services, Pages 1603–1605. Robins, Edith G. *Report on Day Hospitals in Israel and Great Britain*, available through the Division of Long-Term Care, National Center for Health Services Research, H.R.A., D.H.E.W., Rockville, Maryland. 20852. Lamden, Richard S. "Partnership in Out-patient Day Care", *Hospitals, J.A.H.A.* October 16, 1975, Pages 87–89.

On Lok Senior Day Services: Evaluation of A Success, Kalish, Lurie, Wexler and Zawadski, November, 1975.

ON LOK SENIOR HEALTH SERVICES,
San Francisco, Calif., June 10, 1976.

Representative CHARLES VANIK,
Chairman, House Ways and Means Oversight Subcommittee, U.S. House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN VANIK: We have read with interest about your hearings on progress being made by HEW with the Section 222 (1972 Social Security Amendments) experimentation. We have been vitally concerned with this issue, particularly reimbursement for day care and homemaker services.

As you know, up to now only four contracts under the mandate of Section 222, P.L. 92–603, for day care have been authorized. We have been aware of these contracts but have had many reservations about these experiments. One of the main issues relates to cost. From our observations of the 222 projects operating in San Francisco, day care costs are going to prove extremely high, and we fear that experience gained from these very limited experiments might convince legislators that day care is at least financially not a viable alternative to institutionalization.

In view of this, we have been trying to interest the Director of the National Center for Health Services Research in developing other models and test their viability. In particular, we have suggested to use On Lok as one possibility since at the present time we do offer day health (care) services to the elderly under Title XIX and are in contract with the California Department of Health, which is evaluating the experience with us. Up to now, studies which compared similar groups of elderly in nursing homes and at a day health center in the community have shown favorable results for the group kept in the community receiving day health services. The State Department of Health has also been favorably impressed with the cost savings.

Up to now, all our endeavors to get the cooperation of HEW in developing additional projects have remained futile. For your information, we are enclosing copies of the most recent correspondence and some descriptive material on On Lok Senior Health Services.

We hope that your committee will be able to stimulate the necessary interest in HEW to finally move ahead with the mandated tasks of encouraging experiments in alternatives to reimbursable long-term care services, such as, testing of day care (in our terminology, day health) under Section 222 of P.L. 92–603, Section 222(b)(H).

Thank you very much for listening to us.

Very sincerely yours,

WILLIAM L. GEE, D.D.S.,
President, Board of Directors.
MARIE-LOUISE ANSAK,
Executive Director.

Enclosures.

DECEMBER 29, 1975.

MR. GERALD ROSENTHAL,
Director, National Center for Health Services Research,
Rockville, Md.

DEAR MR. ROSENTHAL: On Lok Senior Health Services has developed a comprehensive community-based health care system for the elderly. The day health center and its supportive services were initiated with a research and demonstration grant from the Administration on Aging. A copy of the final evaluation report covering the period from July 1972 through July 1975 is enclosed.

Last year we have been able to negotiate for reimbursement for day health services under the Medi-Cal (Medicaid) program with the California Department of Health as an alternative to nursing home placement. The first year of operation has been satisfactory and the Department found higher patient satisfaction and frequently better care. At the same time the experiment has shown *cost effectiveness.*

Since in our original project guidelines we were encouraged to negotiate for both Medi-Cal and Medi-Care reimbursements, we are now interested in finding out what avenues might be open to us to obtain a waiver for Medi-Care reimbursement.

We would very much appreciate it if you could let us know what steps we would have to take. We feel that On Lok is offering a model which could easily be replicated in other inner cities and offer substantial cost savings to Medi-Care.

Very sincerely yours,

MARIE-LOUISE ANSAK,
Executive Director,
On Lok Senior Health Services.

Enclosure.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
HEALTH RESOURCES ADMINISTRATION,
Rockville, Md., March 22, 1976.

MARIE-LOUISE ANSAK,
Executive Director, On Lok Senior Health Service, San Francisco, Calif.

DEAR MS. ANSAK: This is in response to your letter of December 29, 1975, in which you requested information concerning the availability of waivers for reimbursement for day health services in the On Lok Senior Health Center. We feel certain that you are aware of the fact that the National Center for Health Services Research (NCHSR) is currently funding four contracts under the mandate provided by P.L. 92–603, Section 222 (b) (H) which authorized demonstrations and experiments to test the effectiveness of day care services. As you are well aware, day care services are not currently covered benefits under either Part A or Part B of the Medicare Program.

Waivers for uncovered Medicare services can only be considered if a project proposal receives approval and funding.

The project proposal would have to present a detailed research design, including approved data collection instruments and methodology for carrying out the demonstration and/or experiment. A contractor selected by the Government, and not related to the provider of service, would perform the evaluation of the project.

At the present time, the NCHSR does not plan to fund any additional 222 demonstrations or experiments due to budgeting constraints.

I have heard many good reports about your program designed to serve elderly individuals in the Chinatown community of San Francisco. I was happy to receive a copy of the evaluation report of the Administration on Aging funded project.

Sincerely,

GERALD ROSENTHAL, Ph. D.,
Director.

APRIL 6, 1976.

DR. GERALD ROSENTHAL,
Director, National Center for Health Services Research, Health Resources Administration, Department of Health, Education, and Welfare, Rockville, Md.

DEAR DR. ROSENTHAL: Thank you very much for your recent letter informing us about the present status of Section 222 experiments. We are very sorry to hear that NCHSR does not plan to fund additional demonstrations or experiments

due to budgeting constraints. As you know, we feel very strongly that some other models should be looked at.

We would very much appreciate it if you would let us know in case the policy should change. Thank you.

Very sincerely yours,

MARIE-LOUISE ANSAK,
Executive Director,
On Lok Senior Health Services.

HIGHLIGHTS FROM THE EVALUATION REPORT OF ON LOK SENIOR HEALTH SERVICES

(Original Report Prepared by Kalish, Lurie, Wexler, and Zawadski)

This report, written in January 1976, presents the major procedures, findings, issues, and conclusions from the November 1975, report, "On Lok Senior Health Services: Evaluation of a Success." Both were prepared for the Administration on Aging to present the results of a three-year demonstration and evaluation program of a geriatric day care center established in the Chinatown—North Beach Area of San Francisco.

In 1972, On Lok Senior Health Services was developed as one of a number of Federal Demonstration Projects to test the feasibility of the day care center as an alternative to long-term institutional care. Included in the Federal Grant Guidelines for these projects was the following:

II. STATEMENT OF OBJECTIVES

The proposed project would seek to demonstrate and evaluate the feasibility and cost-effectiveness of providing day care services (medical, social, recreational) for the elderly in a day care center as an alternative to nursing home and other long-term institutional care.

The overall objective would be to evaluate such a program's potential for replicability in other settings and for suggesting legislative changes in benefits to be included in the MediCaid and Medi-Care programs. It would seek answers to such questions as: (1) how many days of institutional care can such a day care center prevent and at what cost savings? (2) how many and what kinds of persons can return to or continue in independent living as a result of the day care services? (3) what services are most effective in reducing or eliminating institutionalization? (4) what are the characteristics of persons for whom such programs seem most effective? (5) how effective is the day care center in helping families to care for an aged parent at home?

Thus, the explicit assumption underlying federal subsidies for geriatric day care programs was the need to reduce health costs for the elderly by developing alternatives to nursing home and other institutional care facilities. In developing the initial proposal, we assumed that geriatric day care could be evaluated as an option to convalescent care. By the time the project had ended, however, we realized that the problem needed to be conceptualized in much different form. This statement will become clear in the development that follows.

At the time the grant proposal was submitted, we developed several hypotheses which served to guide the remainder of the research planning and implementation. The hypotheses are that day treatment in general and On Lok in particular would:

(1) Be a viable alternative to institutional care, more specifically to nursing homecare since there were no intermediate care facilities in the area and since the anticipated On Lok participants would not be drawn from a board-and-care population;

(2) Be cost effective in comparison to institutional, i.e., nursing home, care;

(3) Have a favorable impact on the lives of the participants;

(4) Have a more favorable impact on the lives of the participants than would residential care facilities;

(5) Have a more favorable impact on the lives of the participants than would remaining in the community without either day treatment or an existing health care network;

(6) Be perceived in a positive light by the Chinatown-North Beach community;

(7) Provide significant services to the elderly of the Chinatown-North Beach area;

(8) Provide significant services to others in the community;

(9) Serve as a significant model for comparable programs that other communities might wish to establish.

We were well aware that these hypotheses were not all equally testable and were certainly not all testable in a rigorous fashion. Many of the terms were difficult to operationalize; others were policy issues more than evaluation concerns. Nonetheless, we chose to use these hypotheses as a general framework to guide our procedures and our thinking.

The On Lok Senior Health Center program is described elsewhere (Lurie, Kalish, Wexler, and Ansak, The Gerontologist, 1976, Volume 16, #1). However, as is the case with any dynamic program, On Lok has changed and expanded its services since the above-cited article was written. The most recent materials can be obtained by writing to On Lok Senior Health Services.*

The participants at On Lok during the time of the study were primarily Chinese (half again as many men as women) and Filipino (all men), constituting 73% and 11% respectively of the entire group, almost all of whom were born outside the United States. About 40% were under age 75, and 6% were over 90. Have lived alone at the time of admission. Income level was low; fluency in English was little or none; previous work was likely to be unskilled or semi-skilled.

RESEARCH PROCEDURES

Social history/process description

We wished to describe the process through which On Lok had been organized to provide services, as well as how it has grown and developed and changed. This growth process includes the development of On Lok from its original purpose as an alternative to nursing home care to its present status as a service center with many components. It also includes changes in structure, personnel practices, and social organization during the three-year period covered by the present grant. The information we needed was obtained (1) through our own observations, (2) through interviews conducted with staff members, and (3) through other documents, informal meetings, and related materials.

Social and demographic characteristics

The characteristics of the On Lok participants were determined by the admissions procedures and policies of the organization and by the actual practices based on these procedures and policies. For whom is On Lok actually providing care? What are the demographic, medical, and personal characteristics of the participants? Have these been in the process of change since the initial participants were selected, and if so, what has been the nature of these changes? Among the most important of these measures for our purposes were the ratings of medical status and chronicity, functional status, cognitive status, and level of care required.

Service utilization

The services provided to On Lok participants are extensive and varied. They range from medical examinations to transportation to reality therapy. The research staff instituted a daily record of services rendered to each participant by each staff member, and these records were tabulated monthly for a six-month period.

Costs, effectiveness, and benefits

After the costs of maintaining participants at On Lok were determined, they were compared to the costs of other forms of service delivery. We also investigated the effectiveness of the services and the benefits they provided.

Impact on participants

Perhaps the most significant aspect of the evaluation program was to determine the impact of participation in the On Lok program on the participants

*On Lok Senior Health Services, 1490 Mason St., San Francisco, Calif.

themselves. This impact had to be compared to the impact of other programs for the frail elderly, such as residence in a nursing home. Any measurable changes also had to be compared to the condition of the frail elderly who still lived in the community but lacked the comprehensive services provided by On Lok or by a nursing home.

Impact on the participants was determined in three ways. The first was to use the intake evaluations of medical status, functional capacity, cognitive skills, and, where appropriate, level of care required. These served as baseline measures. We then attempted to replicate the procedures at a time as near to six months after the initial measurement as possible. If the participant had left the program, his status was considered as of his last week of attendance, assuming program participation was at least four months.

Two research assistants reviewed up-dated written records and filled in missing information through informal interviews with social workers and other staff members. These data were normally available for the month during which most of the information was collected, but were occasionally collected as much as six to eight weeks earlier or, in rare instances, six to eight weeks later. To confirm these evaluations, a third research assistant obtained follow-up assessments directly from social workers for all measures and all participants. This is subsequently referred to as Actual Change Ratings.

The second kind of follow-up evaluation was to ask social workers whether they felt the participants had changed (a) for the better, (b) not at all, or (c) for the worse from intake to reassessment. This information was elicited for medical status, cognitive ability, and functional capacity. This is subsequently referred to as Staff Change Rating.

The Staff Change Ratings presumably reflect the actual changes in these criteria, since they come from the same data source, i.e., the staff. The Staff Change Rating, however, is a subjective retrospective judgment based on the staff's (usually the social worker's) opinion at the time of follow-up as to the change in the participant from the time of intake to the time of reassessment (i.e., follow-up). Once again, the status of those who had left the program was considered as of the last week of attendance.

The third measure of change is the evaluation of participant status as perceived by collaterals, i.e., the family member or friend in the best position to judge the capacities of the participant because of close personal contact. In this instance, we restricted our measurement to (a) collateral evaluations of present status at time of reassessment and (b) collateral retrospective evaluations of change from intake to follow-up.

IMPACT OF THE INTERVENTION

In this section, we will discuss the various kinds of impact that the intervention (e.g. the On Lok program) has brought about.

Actual change

Independent pre- and post-measures were collected and evaluated by the On Lok staff for 94 participants on the four core criteria : medical status, functional capacity, cognitive skills, and level of care required. The change in status on these criteria provide the most objective indicator of the impact on On Lok.

Table 1 shows the distributions for the four core criteria as they were assessed at intake and at follow-up. The intake and follow-up distributions were compared for each impact area, and the chi square value under each table reflects the statistical test of independence. Making the tenuous assumption of interval data, the means were computed for each distribution (e.g. Poor=1, Fair=2, etc.), and the differences between intake and follow-up means were compared for each impact area with "t" tests of statistical significance.

In Table 2, we have summarized the actual changes that occur for the four impact areas. This table is readily understood. It shows the percentage of the 94 participants who are shown to be changing either for the better or the worse or not at all.

TABLE 1.—COMPARISON OF INTAKE AND FOLLOWUP DISTRIBUTION FOR THE 4 CORE CRITERIA (N=94)

[In percent]

	Intake	Followup
MEDICAL STATUS		
Poor (has life-threatening condition)	0	3
Fair (has potentially life-threatening condition)	16	8
Good (requires continuous medical supervision)	69	37
Excellent (no medical supervision required)	15	52
X^2=34.35, df=3, prob≦.001		
t= 4.10, df=93, prob≦.001	M^I=2.99	M^F=3.38
FUNCTIONAL STATUS		
Poor	44	20
Fair	40	53
Good	12	24
Excellent	4	3
X^2=13.51, df= 3, prob≦.01		
t= 3.96, df=93, prob≦.001	M^I=1.77	M^F=2.10
COGNITIVE STATUS		
Poor	22	10
Fair	22	41
Good	24	39
Excellent	32	10
X^2=25.32, df= 3, prob≦.001		
t= 1.80, df=93, prob=NS	M^I=2.65	M^F=2.49
LEVEL OF CARE REQUIRED		
Extended care facility	0	1
Skilled nursing facility	0	6
Intermediate care facility	2	2
Protective residence	15	7
Self-care with assistance	75	73
Self-care	8	10
X^2=9.40, df= 5, prob=NS		
t=1.50, df=93, prob=NS	M^I=4.89	M^F=4.7

TABLE 2.—DISTRIBUTION OF CHANGE SCORES (STATUS AT FOLLOWUP COMPARED TO STATUS AT INTAKE) FOR THE 4-CORE CRITERIA (N=94)

[In percent]

	Worse	Same	Better
Medical	17	31	52
Functional	10	53	37
Cognitive	31	52	17
Level of care required	17	69	14

As can be seen from these two tables, the greatest overall improvement in terms of actual change can be seen in medical status. Substantial improvement also occurred in functional status. When the participants entered On Lok, many required medical supervision, although none faced a life-threatening situation. By the time of follow-up, only a very small percentage (3%) had deteriorated to a point where their medical condition was life-threatening. Conversely, a large percentage improved in their medical status to a point where no supervision was required. Overall, 53% of the participants improved medically while 17% became worse. Both the chi square and the "t" tests were highly statistically significant, indicating that this change was not the result of chance factors.

When we turn to functional status, there is again a highly significant overall improvement from intake to follow-up. Well over two out of every five participants were rated functioning poorly at intake. Only one out of five were so rated at follow-up. In general, the participants were most likely to change from having poor functional capacity to having fair functional capacity. Nearly four times as many participants improved in this dimension as became less capable, although the greatest number of individuals were seen as not exhibiting any change.

The changes in cognitive skills as measured by the intake/follow-up comparison is a little more complex, depending upon which statistic we consider. When we compare the mean score on cognitive status at intake with the mean score at follow-up, there is almost no change. On the average, therefore, the group has neither improved nor become worse. However, when we compare the distribution of scores at intake with the distribution of scores at follow-up, we find major changes, easily attaining statistical significance. This results from having 46% of the participants rated as fair or good at intake, but 80% receiving these ratings at follow-up, with comparable drops in ratings of poor and excellent. In essence, there has been a considerable shift away from the extremes into the middle ground. It is as though On Lok had a homogenizing influence, improving the cognitive skills of those who were previously least effective, but not inhibiting the decrements in such skills among those who were most effective.

No discernible change was noted in level of care required from intake to follow-up. Some 75% of the participants at intake were capable of self-care with some assistance, and roughly the same number were found in this category at follow-up. There was a tendency, nonetheless, for some participants to require a higher level of care at follow-up, probably reflecting those participants who were also showing medical status decrement. Seventen percent of the participants moved to a higher care classification at followup while roughly the same percentage (14%) were classified as requiring less care.

Staff rating of change

At the time of follow-up, the staff was asked to evaluate change in each of the three impact areas (see Table 3). Like the previous set of measures, the greatest improvement was seen in medical status, with less improvement in functional status, and an essential status quo in cognitive status. Nonetheless, staff change ratings were much more likely to show improvement than decrement for all three impact areas and were similarly much more likely to show improvement than were what we have termed "actual change" ratings.

TABLE 3.—PERCENTAGE OF PARTICIPANTS SEEN BY STAFF AS CHANGING IN 3-CORE CRITERIA (N=94)

	Worse	Same	Better
Medical	11	24	65
Functional	12	33	55
Cognitive	1	67	32

Collateral ratings

Of the 94 participants included in this data analysis, 62 had identifiable collaterals, usually a close relative but occasionally a more distant relative, a friend, a roommate, or even a landload. Each collateral was asked to make two kinds of ratings. First, s/he was requested to evaluate the skill level of the participant on 11 tasks. Then each was asked to rate whether the participant was better, the same, or worse than at admission to On Lok in regard to each task. The responses are provided in Table 4.

Collaterals indicated that the participants were most likely to have difficulties in climbing stairs, in walking unaided, and in dressing without help. Almost all participants were seen as capable of feeding themselves, and about three-fourths were perceived as able to recognize people around them and to know their physical locations.

The majority of participants, in some instances as high as 90%, were seen as being unchanged in the ability to perform each of the 11 tasks. In most cases, more participants improved than deteriorated. The only tasks that showed more people displaying loss than displaying improvement were the two memory-related tasks. About half again as many participants were seen as having a less adequate memory, both for recent events and for past events, at the time of follow-up than at intake. The greatest improvement was found in tasks related to functional capacity, but that also obviously reflected both physical health and cognitive skills. These included improvement in walking (37% seen as improved), dressing (31%), climbing stairs (28%), and feeding themselves (26%).

TABLE 4.—DISTRIBUTION OF LEVEL AND CHANGE IN SKILLS AS SEEN BY COLLATERALS OF THE PARTICIPANTS (N=62)

[In percent]

Skill	Level			Change		
	Can not do it	Receives or requires assistance	Can do it	Worse	Same	Better
Dresses self	14	20	66	3	66	31
Feeds self		6	94	0	74	26
Walks unaided	11	50	39	7	56	37
Climbs stairs	13	56	30	5	67	28
Converses rationally	2	40	58	11	74	15
Remembers recent events	3	51	46	20	69	11
Remembers past events	10	37	53	13	78	8
Knows physical location	5	22	73	5	81	14
Recognizes people	2	19	79	5	87	8
Relates to relatives	8	34	58	3	93	3
Relates to strangers	6	48	46	0	94	6

COST STUDIES

The cost studies focused on two major areas: (1) determination of internal On Lok operating costs, and (2) comparable costs for nursing homes and intermediate care providers for these services.

The basic problem in comparing On Lok's costs with those of other services is that the On Lok delivery system could not be compared with present delivery patterns. At On Lok there was an emphasis on sharing of activities that results in a considerable cross-over among positions. One routinely found the aides helping the patients carry out physical therapy, the social worker assisting participants with toileting, or the drivers involved in a recreation program. Another complication was that individual services are tailored to the needs and the receptivity of the participant. As a result, three five-minute therapy sessions may be given during the course of the day instead of a single formal 15-minute session and it was not at all uncommon to find the participant doing additional exercises on his own.

Because of this unique pattern of delivering services, traditional measures of utilization and cost analysis are not only difficult to develop but would not appropriately represent the On Lok program. To circumvent this problem and to present a more meaningful basis for comparison with other similar service providers, we decided to look at the total "bottom line" costs of operation. This would not only eliminate the problems described earlier but would involve a figure, i.e. prevailing rates, that was more readily obtainable from the other providers.

Secondly, it was decided to break down the total costs of operation into major cost centers. Identification of these individual cost centers was based on many factors, including (1) requirements imposed by the recently-negotiated Medicaid contract, (2) information required for potential Medicare reimbursement of present "covered services," (3) present Older American Act programs that fund individual services, (4) traditional cost centers of existing delivery systems, and (5) internal On Lok needs for program monitoring, control, and decision-making. Liberties were also taken in certain areas where it was necessary to conform to or at least compare results with data provided by the California Department of Health. These factors resulted in the identification of the following major cost centers: (1) Administration, (2) Medical Services, (3) Therapeutic Services, (4) Social Supportive Services, (5) Transportation, and (6) Nutrition/Meals.

To provide a basis for comparison with institutional facilities, we obtained cost data from nursing homes, intermediate care facilites, and physical, occupational, and speech therapists as well as MediCal monthly reimbursement figures for all health services for the aged during the calendar year 1974 and the first two months of 1975, both for Alameda County, which has intermediate care facilities, and for San Francisco, which does not.

In any case, analyzing the budget is a complicated matter. For example, Therapeutic Services appears to occupy a relatively low percentage of the budget at On Lok: the daily cost per patient is $1.49 as compared to the state figure of $1.70 per patient. However, consideration should be given to the fact that On Lok is providing "group services," i.e. patients are brought to the therapist by the transportation service thus increasing the therapist's efficiency. In addition, the attractive noon day meals provided by On Lok could be an added incentive for participants to attend the center. Viewed in this manner, transportation and nutrition could be considered as either basic therapy costs or overhead to these costs resulting in a daily cost per patient equivalent to that the State reports.

TABLE 5.—ON LOK COSTS FOR MAJOR COST CENTERS (MONTH OF MAY 1975)

	Total cost		Average cost per unit	Average cost per patient	
	Month	Day		Month	Day
Administration	5,876	196	NA	77.32	2.58
Medical services	6,762	225	11.50	88.97	2.96
Therapeutic services	3,375	113	8.13	44.41	1.49
Social supportive	6,067	202		79.83	2.66
Transportation	4,983	166	5.72	65.57	2.18
Nutrition	4,746	158	2.54	62.45	2.07
Total	31,809	1,060		418.54	13.94

TABLE 6.—COSTS FOR 3 ELDERLY CARE ALTERNATIVES FOR 100 PATIENTS

Monthly	On LOK	Skilled nursing facility [1]	Intermediate care facility
Program costs	$31,809.00	$54,300.00	$39,570.00
Therapy		5,167.00	5,167.00
SSA subsidy	23,500.00	2,500.00	2,500.00
Total	55,309.00	61,967.00	47,237.00
Patient cost per:			
Year	6,637.08	7,436.04	5,668.44
Month	553.09	619.67	472.37
Day	18.44	20.66	15.74

[1] Data supplied by the California Department of Health.

In determining the cost effectiveness of On Lok, we have compared the program with skilled nursing facilities (SNF) and intermediate care facilities (ICF).

The external figures used in the cost presentations are the prevailing rates of proprietary nursing homes, MediCal reimbursement rates and average therapy costs obtained in information from the Health Financing Systems Division.

DISCUSSION: HYPOTHESES REVISITED

Hypothesis One.—Day treatment in general and On Lok in particular will be a viable alternative to institutional care, specifically to nursing homes.

Many frail elderly reside in institutions not because their condition requires such care but because their needs cannot be met by presently available facilities in their home community. For these individuals, our findings indicate that day health centers in general and On Lok in particular are viable alternatives to institutional care.

At this juncture, we would prefer another question: What proportion of residents of institutions could be released to a less intensive health care system or to the community, given the availability of a day health center? This question can be answered only in terms of specific communities, based on knowledge of the available institutions and on the kinds of services to be provided by the day health center. On Lok has responded to the needs of the transportable but not necessarily ambulatory frail elderly and, therefore, filled an important gap in services in this particular community. A day health center that provides services

for only the ambulatory relatively healthy but socially isolated frail elderly would fill an equally important but quite different gap. It is difficult, perhaps impossible, to compare the two kinds of facilities in general, although we can evaluate each facility in terms of the community needs of the frail elderly in the community where each exists.

We encourage looking at the needs of the service recipient rather than at the structure of the service-providing agency. In any given community, some of the needs of the frail elderly are already being met and some are not. If the establishment of a new form of service—in this instance, a day care/treatment center—can be developed as an effective way to provide those services, that new form of service will help reduce the need for residential care institutions.

We believe that the hypothesis, while not actually meaningless, puts forth the wrong issue. The issue is what services in a particular community will enable *certain kinds of individuals* to remain for longer periods of time in that community and out of institutions. And this, we wish to emphasize, requires that we rethink the present classification system of skilled nursing facilities, intermediate care facilities, and day health centers. By looking at the needs of the individuals, which may vary from 24-hour custodial services to rehabilitation, maintenance, and socialization, we can think in terms of generating new concepts of care and, perhaps, develop new forms of institutions, or at least modify the present form appropriately.

In concluding this statement, we fully believe that On Lok in particular and day treatment in general can be an effective method of providing integrated services to meet the needs of some frail elderly in such fashion as to keep those elderly out of institutions.

Hypothesis Two.—Day treatment in general and On Lok in particular are cost effective in comparison to residential care institutions.

Like the previous hypothesis, this raises an issue that, after examination, is seen as misleading. There are several reasons for this. The first is that day health centers and residential care facilities respond to different needs and serve different populations. The fact that there is overlap in individuals served often arises from inappropriate nursing home placement due to lack of adequate community support facilities.

Second, the cost of day health centers or, for that matter, of residential care facilities, is a function of the services provided as well as of the efficiency and effectiveness with which they are provided. It is both easy and dangerous to confuse "low cost" with "cost effectiveness." There is no basis for assuming that day health centers in general will reduce costs to the public sector more than alternative categories of care. This depends on what added services are part of the day center package, and this is a policy issue.

Third, how much financial value do we put on the advantages that On Lok provides to its participants? That is, how much is it worth for one elderly person to spend one more month in his home community where he has friends and where he can communicate in his own language? Until we can answer that question, we cannot fully respond to the hypothesis.

The basic point is that day health centers should not be compared with residential health centers. They each have a vital function to perform. The issue is how to avoid sending people to nursing homes when they could remain in the community, and this is primarily a policy issue.

Hypothesis Three.—Day treatment in general and On Lok in particular will have a favorable impact on the lives of the participants.

We have no difficulty in affirming this hypothesis. First, we have our own subjective perceptions. A visit to On Lok at any time or at any day offers the opportunity to see a highly active staff work with and relate to an amazingly active group of participants. Further, the participants are working with and relating to each other in a surprisingly vital fashion.

Second, the attendance at On Lok is high. The percentage of actual participant days-in-attendance based on the scheduled participant days-in-attendance is over 90%. And these are, for the most part, people with choice; they are not forced to attend but come because they wish to be there.

Third, On Lok participants become physically healthier and more capable of functioning effectively during their time at On Lok. Perhaps some of this improvement would have occurred if they had remained at home, but the normal trend for these kinds of frail elderly is to show decrement over time. At On Lok they show improvement. We interpret the data to show that On Lok is a major, very likely *the* major, factor in their improvement.

Fourth, many participants continue to function at a high level. Our follow-up measures were made six to nine months after entering On Lok. Major changes tend to occur within the first few weeks due to the availability of a nutritious meal or the opportunity to socialize with friends. At On Lok the changes seem to be sustained beyond these few weeks.

Fifth, fewer On Lok participants displayed poor cognitive functioning following several months at On Lok.

Sixth, family members and friends confirm the findings of improved functional capacity, while indicating relatively little change in cognitive skills. They further attest to the improved mood and greater happiness of the On Lok participants. Very few have withdrawn the elderly individual because of unhappiness with the program.

Hypothesis Four.—Day treatment in general and On Lok in particular have a more favorable impact on the lives of the participants than residential care facilities, particularly nursing homes.

The data do not answer this question in any meaningful fashion. First, we cannot compare day treatment in general with residential care facilities because our project was limited to On Lok. Second, On Lok participants are not comparable to any particular group of participants in any other care facility.

When we examine the data from our comparison-group study, we find that nursing home participants are perceived by those who work with them as showing improvement or, at least maintaining the status quo, when viewed retrospectively. We have difficulty believing this, but there is no other source of data on this comparison group.

At On Lok, the money and the energy are put into programs directed at rehabilitation and enhancement. In nursing homes and other institutions, the money and energy are put into physical plant and custodial arrangements. Their roles are different; their patients/participants are, or should be, different; their staffing patterns are different; their time involvement with the elderly is different. Nursing homes will have a more favorable impact on the life of a confused, incontinent elderly man who requires 24-hour medical maintenance, the kind of person On Lok cannot deal with under its present program. On Lok will have a more favorable impact on the life of a moderately alert and intact, recuperating stroke patient who lives with his older sister; in short, an individual who need not be in a nursing home given other community supports.

In essence, if an individual requires the kind of care that a nursing home can give, and if he has no option for receiving this care in the community, he may be better off in a nursing home. If On Lok, or a combination of On Lok and other resources, can sustain an individual in the community by taking care of his needs, he is better off at On Lok.

Hypothesis Five.—Day Treatment in general and On Lok in particular will have a more favorable impact on the lives of their participants than remaining in the community without either day treatment or an existing health care network.

Once again, our data did not respond appropriately to the issue. Our subjective perceptions are that such individuals would deteriorate more rapidly, *assuming* that they had unmet needs comparable to the unmet needs of the On Lok participants. That is, we would wish to evaluate two groups, one at On Lok and one in the community, on the basis of previously met and previously unmet needs, as well as the basis of health or functional status.

Again we return to the conclusion that we have drawn continually throughout this report: various kinds of health care facilities for the frail elderly should not be in competition but that each kind of facility and each individual faclity should be operated in such fashion as to optimize its own effectiveness. New facilities and kinds of facilities should be developed and tailored to unmet needs, not to pre-established structure based on unnecessary classification systems. Further, any given health care facility can only be as effective as its capability in directing patients/participants into more appropriate facilities at appropriate times. Thus, a day health center can be most effective if it is linked with a multi-purpose senior center and a number of residential care facilities, so that day health center participants can be directed toward the former, if they regain previous standards of functioning, or to the latter if deterioration increases. Otherwise the day health center is faced with the unpleasant choice of keeping on the roster an individual who can benefit more by another facility or dropping from the roster an individual who has no other appropriate support facility.

Hypothesis Six.—On Lok is perceived in a positive light by the Chinatown-North Beach community.

We did not have the resources to study the Chinatown-North Beach community as a totality, but we do have several sources of information that permit us to substantiate the appeal of On Lok: (1) The collaterals were virtually unanimous in approving the On Lok program; (2) On Lok has been widely publicized in a most favorable way through local newspapers, feature sections, magazines, radio, and television; (3) On Lok has been widely publicized at the national level, and inquiries arrive almost daily from throughout the country; and (4) Personal experiences and incidental observations indicate widespread community approval and pride.

Hypothesis Seven.—On Lok will provide significant services to the elderly of the Chinatown-North Beach area.

We have described in our complete report the range and frequency of services offered at On Lok. We interpret these findings as indicating that the On Lok participants are receiving many varied and appropriate services.

Hypothesis Eight.—Day treatment in general and On Lok in particular will provide significant services to others in the community.

Here we can again provide an affirmation of our hypothesis based on data, in this case the very positive responses of the collaterals, the family members and close friends, of the On Lok participants.

On Lok has provided community services in other ways as well. It has shown that a multi-ethnic facility can bring together persons from different ethnic communities. Good will has been evident not only among the participants, but also among the staff and the Board of Directors, both made up of persons of Chinese, Filipino, Italian, and other origins. Furthermore, On Lok provides jobs for a score or more of unskilled and semi-skilled men and women, along with additional jobs for college-trained staff, which is a significant service in a community with the high unemployment of Chinatown-North Beach.

Hypothesis Nine.—On Lok will serve as a significant model for comparable programs that other communities might wish to establish.

For this hypothesis we have only two general sources of information, both affirming the significance of On Lok. The first source of information is our own subjective impressions that On Lok has worked, has provided meaningful services, has kept costs at a reasonable level, is cost effective, and is a worthwhile model for others to observe. At the same time, it is obvious that each new facility needs to establish itself in its own community, with its own unique concerns and its own group of frail elderly.

The second source of information is the considerable interest in On Lok evidenced by considerable publicity, both local (*San Francisco Magazine*) and national (*Newsweek*), an abundance of letters requesting information, and the general interest that all associated with On Lok have encountered.

REEXAMINING ORIGINAL OBJECTIVES

Returning once again for a look at the five objectives originally set forth in the Federal Guidelines, let us see to what extent they may be answered.

1. How many days of institutional care can be prevented by a day care center such as On Lok and at what cost savings? The response to this depends on what criterion we use to decide which present On Lok participants would otherwise be in a long-term care institution. We have contended that the question has little significance, since the answer is unascertainable within the boundaries of our project and, very likely, unascertainable under any circumstances. We also believe that basing financial savings on the differences between money outlay is, in spite of its apparent objectivity, also irrelevant. If a frail older person can remain in the community by virtue of being at On Lok, it means that a great deal of what was paid for in the nursing home or other institution was *wasted*. What is received at On Lok is presumably, although we cannot prove it, worthwhile; at least the participant isn't in the nursing home. On Lok moneys are paying for services that are needed, not for custodial care that is required only because adequate community resources are lacking.

Actually, day care provides a substantial financial savings because an unnecessary cost center, custodial care, is eliminated; but for how many persons this can be accomplished or for specifically how much money are problems still under evaluation.

2. How many and what kinds of persons can return to or continue in independent living as a result of day care services? As with the previous question, this issue may be answerable only for specific settings on a specific basis. The kinds of persons who can return to the community are those individuals who

need not have been in the nursing home to begin with, had community resources been adequate. The more adequate the community resources, including family resources, the fewer individuals will require institutional care. To try to count them or categorize them other than in terms of what new facilities are available to meet previously unmet needs makes no sense. As for which elderly persons can be enabled to remain in the community, the response is the same, i.e. those persons who need services now available that previously had not been available. As far as contemplating which elderly persons the day health center keeps healthier, this issue, although fascinating, goes far beyond the limits of this report. It involves physical health, morale, family support systems, health care adequacy, welfare regulations, MediCaid aavilability, and a host of other variables.

3. What services are most effective in reducing or eliminating institutionalization? This is a reasonable but unbelievably complex question. For example, both reality therapy and a high protein lunch influence cognitive performance. The cost in time and money to devise programs where each would be used without the other while controlling other variables is great. Whether the results would be worth depriving some participants of good nutrition and others of reality therapy is questionable. Therefore, other approaches, perhaps depending on the experience of DHC directors and staff may be required. Further, it is likely to turn out to be the interaction or combination of various services that provide optimum benefit.

4. What are the characteristics of persons for whom such programs seem most effective? Again a valid question. Again, virtually unanswerable. They are the individuals whose unmet needs are met by the newly developed services. If On Lok staff and facilities attempted to cope with a confused, paranoid individual or with someone who could neither sit nor stand, we would need to conclude that such individuals cannot profit from day health centers. This is obviously not the case. They cannot profit from On Lok because it is not set up for such participants, whereas at another center such participants might thrive; conversely, an intact, essentially healthy stroke patient now on the road to recovery might deteriorate as the result of experience elsewhere but possibly would thrive at On Lok.

5. How effective is the day care center in helping families to care for an aged patient at home? Here we can give an answer. The day care center is extremely helpful.

Not among our original hypotheses or objectives is one conclusion that we feel strongly must receive considerable attention: the continuum of needs. Existing agencies are sometimes described as providing a continuum of care, but this approach—albeit an improvement over perceiving care as a series of discreet and uncoordinated operations—requires that we view the world from the position of the formal agency rather than from the position of the persons requiring services. We propose that geriatric day care centers be seen as entities that respond to a number of needs of the elderly, selected from a universe of needs that are presently unmet in that given community and that fall within the purview of what a day care center is. This alteration is more than semantics, since it will focus attention on the individuals receiving services rather than the formal structure of the agencies providing the services. Further it views the geriatric day care centers as one approach to responding to certain needs of the elderly, simultaneously providing linkages with other agencies responding to the needs of the same elderly that are unmet through the day care center and to those agencies responding to the needs of the elderly for whom day care centers are not appropriate.

In summary and prior to our recommendations, we encourage future federal guidelines to ask different questions, and we simultaneously support the very difficult and more theoretical work necessary to answer some of the questions already raised.

RECOMMENDATIONS

Many recommendations are contained throughout this document, some explicit and some implicit. At this point, we will reiterate only those we consider most important.

1. The entire notion of geriatric day health centers as alternatives to residential care institutions is given too much prominence. In its place we suggest the development of a continuum of services that will respond to a continuum of needs displayed by the frail elderly.

2. Cost effectiveness comparisons between different kinds of health care facilities for the frail elderly should be given minimal credence except in those instances when the goals are comparable, the populations served are comparable, and the services or the effects of the services are comparable. This is not because the concept of cost effectiveness is inappropriate, but because comparison between different kinds of facilities are often misleading.

3. Consideration should be given to altering the present programs based on presently accepted classifications of care for the elderly (i.e. skilled nursing home, board-and-care facility, day treatment center) to permit analysis on the basis of patient need (e.g. 24-hour custodial care, socialization, maintenance).

4. Greater emphasis should be given to coordination between care facilities, not in order to avoid overlap but to eliminate the necessity of any particular facility having to choose between (a) ignoring the needs of a patient who has developed differing needs than those the facility can respond to, and (b) responding to the needs of a patient when such responsiveness is no longer in the normal repertoire for that facility.

5. Day health centers give evidence of being a valuable approach to the distribution of a number of services in response to a large number of needs of the frail elderly. There is every reason to believe that such facilities should be expanded and that innovative approaches to such services should be encouraged.

6. Funding agencies, including MediCare and MediCaid, should be strongly encouraged to include appropriate day treatment centers as facilities deserving of reimbursement.

7. Funding agencies should provide rewards to day treatment centers and other facilities for improving patient status (if this can be adequately ascertained), rather than for caretaking only.

8. Encouraging one facility or one category of facility to appear less costly than other facilities or categories of facilities should be stopped when such encouragement is likely to lead to cost savings to the detriment of services and effectiveness of programs.

9. While research of the type described in this document does have modest value, it is both too small in scope and too brief in time to be able to respond to the questions posed. We would recommend that a comprehensive study be conducted, based on a careful planning period and permitted to run for at least five years, with the potential for continued follow-up. We also recommend that persons undertaking such a study be given adequate lead time to contact those in the field who have already experienced the frustrations and difficulties of trying to apply sound research methods to dynamic and fluctuating programs. Otherwise, they will only repeat the mistakes of their predecessors.

10. Cost centers should be established, as we have done for this report, and these cost centers should be compared across institutions offering comparable services to comparable population groups. Such cost centers should also be compared for any one institution across time. Eventually it may become possible to compare cost centers for differing kinds of institutions.

11. The development of standardized instruments for measuring the capacities of the frail elderly should be undertaken, with particular attention to such factors as cultural differences, language differences, and physical handicaps. This might require parallel forms.

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